

SERFF Tracking Number: ARBB-127623265 State: Arkansas
Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 49768
Company Tracking Number: 23-2607,23-2608, 23-2609 8/11
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Amendments
Project Name/Number: GMC Amendments/23-2607, 23-2608, 23-2609 8/11

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: Amendments

SERFF Tr Num: ARBB-127623265 State: Arkansas

TOI: H16G Group Health - Major Medical

SERFF Status: Closed-Approved-
Closed State Tr Num: 49768

Sub-TOI: H16G.001A Any Size Group - PPO

Co Tr Num: 23-2607,23-2608, 23-
2609 8/11 State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Christi Kittler, Yvonne
McNaughton, Frank Sewall, Rita
Thatcher, Evelyn Laney

Disposition Date: 09/15/2011

Date Submitted: 09/13/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: GMC Amendments

Status of Filing in Domicile: Pending

Project Number: 23-2607, 23-2608, 23-2609 8/11

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Arkansas is 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: 09/15/2011

State Status Changed: 09/15/2011

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 23-2607, 23-2608, 23-2609 8/11 for your review and approval if indicated.

These documents add language to administer Medical Loss Ratio rebates, amend the rescission provision and to add mandated Blue Cross and Blue Association language where applicable.

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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 policies to which these amendments are attached.

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

Arkansas Blue Cross and Blue Shield CoCode: 83470 State of Domicile: Arkansas
 601 S. Gaines Street Group Code: Company Type:
 Little Rock, AR 72201 Group Name: State ID Number: N/A
 (501) 378-2967 ext. [Phone] FEIN Number: 71-0226428

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? No
 Fee Explanation: \$50.00 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Arkansas Blue Cross and Blue Shield	\$150.00	09/13/2011	51531696

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/15/2011	09/15/2011

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Disposition

Disposition Date: 09/15/2011

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

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Form Schedule

Lead Form Number: 23-2607 8/11

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/15/2011	23-2607 8/11	Certificate	Amendment Amendmen t, Insert Page, Endorseme nt or Rider	Initial		40.300	23-2607 8-11 GMC Amendment.p df
Approved-Closed 09/15/2011	23-2608 8/11	Certificate	Amendment Amendmen t, Insert Page, Endorseme nt or Rider	Initial		40.300	23-2608 8-11 Dental GMC Amendment.p df
Approved-Closed 09/15/2011	23-2609 8/11	Certificate	Amendment Amendmen t, Insert Page, Endorseme nt or Rider	Initial		40.300	23-2609 8-11 GMC Amendment.p df



AMENDMENT NO. 2607

Form Nos. GMC-3, GMC-7, GMC-9BE, GMC-12, GMC-15 and GMC-16

COVENANTS OF THE POLICYHOLDER is hereby amended to add the following new provision.

L. Policyholder to Distribute and Account for Premium Rebates

In the event federal or state law requires the Company to rebate a portion of an annual premium payment, Company will pay the Policyholder the total rebate applicable to the Policy, and Policyholder, on behalf of the Company, will distribute from the rebate a pro-rata share of the rebate to each Employee and former Employee based upon their contribution to the premium rebated.

Policyholder shall assure appropriate notification to federal and state tax agencies and that each payment to Employees and former Employees will be accompanied by appropriate federal and state documentation, e.g. Form 1099.

Policyholder shall develop and retain records and documentation evidencing accurate distribution of any rebate and shall provide such records to Company upon request. Such records shall include:

1. The amount of the premium paid by each Employee;
2. The amount of the premium paid by the Policyholder;
3. The amount of the rebate provided to each Employee;
4. The amount of the rebate retained by the Policyholder; and
5. The amount of any unclaimed rebate and how and when it will be or was distributed.

Policyholder will assure that any unclaimed rebate amounts will be reported in accordance with the unclaimed property laws of the applicable Employee's state of domicile.

Policyholder will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Policyholder's failure to carry out its obligations under this Section L of the Group Policy.

GENERAL PROVISIONS, "Right of Rescission" is hereby amended to read as follows.

F. Right of Rescission

Fraud or intentional misrepresentation of material fact(s) may be used by the Company as the basis for rescission of coverage of the Policyholder, any Employee or any Dependent.

GENERAL PROVISIONS, "Termination of This Policy" is hereby amended to add the following new provision.

8. If this Policy terminates due to nonpayment of premium, the Policyholder may be eligible for reinstatement in the sole discretion of the Company, provided certain conditions are met. The following items are required to be submitted for reinstatement to be considered.
 - a. Payment via cashier's check for all premiums due;
 - b. Payment via cashier's check of a non-refundable reinstatement application fee in the amount of \$350 (or such other amount as may be deemed by Arkansas Blue Cross to cover reinstatement processing); and
 - c. Completion and return of a signed group application for reinstatement.

A reinstatement request, together with the above requirements must be submitted within fifteen (15) days of the date on the "confirmation of termination" letter. The

reinstatement request will then be forwarded to a designated underwriter for review. Following review (which the Company will attempt to complete on most applications within 3-5 business days), the Policyholder will be notified of the decision regarding the reinstatement request.

GENERAL PROVISIONS, "Refund of Premiums" is hereby amended to read as follows.

I. Refund of Premiums

If the Company terminates the coverage of a Covered Person, premium payments received on account of the terminated Covered Person applicable to periods after the effective date of termination shall be refunded to the Employer, unless the Covered Person had made a contribution to the premium and there was no basis for rescission. Such refund shall be made within 30 days, and the Company shall have no further liability under this Group Policy.

If the Employer terminates coverage of a Covered Person, the Company shall refund premium payments applicable to periods after the effective date of termination, provided that the Employer can demonstrate that the Covered Person made no contribution to such premium payments. The Employer must request the Company refund premiums paid for such Covered Person's coverage within 60 days from the effective date of termination of such coverage. Failure of the Employer to make a refund request within 60 days of the effective date of termination of the Covered Person's coverage shall result in the Employer waiving refund of any premiums paid for such coverage. If claims have been paid past the termination date, the payment amount of the claims will be deducted from premium refunds.

GENERAL PROVISIONS, "BlueCard" is hereby amended to read as follows.

P. Out-of-Arkansas Services

The Company has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Covered Persons access healthcare services outside the geographic area the Company serves, the State of Arkansas, the claim for those services may be processed through one of these Inter-Plan Programs and presented to the Company for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Covered Persons under this contract are described generally below.

Typically, Covered Persons, when accessing care outside the geographic area the Company serves, 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, Covered Persons may obtain care from non-participating healthcare providers. The Company's payment practices in both instances are described below.

1. BlueCard[®] Program

Under the BlueCard[®] Program, when Covered Persons access covered healthcare services within the geographic area served by a Host Blue, the Company will remain responsible to you for fulfilling our contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

2. Liability Calculation Method Per Claim

- a. The calculation of the Covered Person liability on claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to the Company by the Host Blue.
- b. Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to the Company by the Host Blue may

represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

- (i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or
- (ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or
- (iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

- c. Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Covered Person is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to the Company is a final price irrespective of any future adjustments based on the use of estimated or average pricing.
- d. A small number of states require a Host Blue either (i) to use a basis for determining Covered Person liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Company would then calculate Covered Person liability in accordance with applicable law.

3. Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

4. Non-Participating Healthcare Providers Outside Arkansas Blue Cross and Blue Shield Service Area

a. Covered Person Liability Calculation

When covered healthcare services are provided outside of the Company's service area by non-participating healthcare providers, the amount(s) a Covered Person pays 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, the Covered Person may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment the Company will make for the covered services as set forth in this paragraph.

b. Exceptions

In some exception cases, the Company may pay claims from non-participating healthcare providers outside of the Company's service area based on the provider's billed charge, such as in situations where an Covered Person did not have reasonable access to a participating provider, as determined by the Company in our sole and absolute discretion or by applicable state law. In other exception cases, we may pay such a claim based on the payment we would make if the Company were paying a non-participating provider inside of our service area, as described elsewhere in this contract, where the Host Blue's corresponding payment would be more than the Company's in-service area non-participating provider payment, or in our sole and absolute discretion, we may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Covered Person may be responsible for the difference between the amount that the non-participating healthcare provider bills and payment the Company will make for the covered services as set forth in this paragraph.

This Amendment shall become part of the Group Policy, and all provisions of the Group Policy not in conflict herewith remain in full force and effect.



P. Mark White, President and Chief Executive Officer

Arkansas Blue Cross and Blue Shield
601 Gaines Street
Little Rock, Arkansas 72201



**AMENDMENT NO. 2608
Form Nos. GMC-4, GMC-10**

GENERAL PROVISIONS, "Termination of This Policy" is hereby amended to add the following new provision.

8. If this Policy terminates due to nonpayment of premium, the Policyholder may be eligible for reinstatement in the sole discretion of the Company, provided certain conditions are met. The following items are required to be submitted for reinstatement to be considered.
 - a. Payment via cashier's check for all premiums due;
 - b. Payment via cashier's check of a non-refundable reinstatement application fee in the amount of \$350 (or such other amount as may be deemed by Arkansas Blue Cross to cover reinstatement processing); and
 - c. Completion and return of a signed group application for reinstatement.

A reinstatement request, together with the above requirements must be submitted within fifteen (15) days of the date on the "confirmation of termination" letter. The reinstatement request will then be forwarded to a designated underwriter for review. Following review (which the Company will attempt to complete on most applications within 3-5 business days), the Policyholder will be notified of the decision regarding the reinstatement request.

GENERAL PROVISIONS, "Right of Rescission" is hereby amended to read as follows.

- F. Right of Rescission
Fraud or intentional misrepresentation of material fact(s) may be used by the Company as the basis for rescission of coverage of the Policyholder, any Employee or any Dependent.

GENERAL PROVISIONS, "Refund of Premiums" is hereby amended to read as follows.

- I. Refund of Premiums
If the Company terminates the coverage of a Covered Person, premium payments received on account of the terminated Covered Person applicable to periods after the effective date of termination shall be refunded to the Employer, unless the Covered Person had made a contribution to the premium and there was no basis for rescission. Such refund shall be made within 30 days, and the Company shall have no further liability under this Group Policy.
If the Employer terminates coverage of a Covered Person, the Company shall refund premium payments applicable to periods after the effective date of termination, provided that the Employer can demonstrate that the Covered Person made no contribution to such premium payments. The Employer must request the Company refund premiums paid for such Covered Person's coverage within 60 days from the effective date of termination of such coverage. Failure of the Employer to make a refund request within 60 days of the effective date of termination of the Covered Person's coverage shall result in the Employer waiving refund of any premiums paid for such coverage. If claims have been paid past the termination date, the payment amount of the claims will be deducted from premium refunds.

This Amendment becomes a part of the Dental Group Policy. All other provisions of the Dental Group Policy remain in full force and effect.

P. Mark White

P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD
601 S. Gaines Street
Little Rock, Arkansas 72201



**Arkansas
BlueCross BlueShield**
An Independent Licensee of the Blue Cross and Blue Shield Association

**AMENDMENT TO THE
ARKANSAS BLUE CROSS AND BLUE SHIELD
GROUP MASTER CONTRACTS**

**AMENDMENT NO. 2609
Form No.GMC-13**

GENERAL PROVISIONS, “Right of Rescission” is hereby amended to read as follows.

F. Right of Rescission

Fraud or intentional misrepresentation of material fact(s) may be used by the Company as the basis for rescission of coverage of the Policyholder, any Retiree or any Dependent.

GENERAL PROVISIONS, “Termination of This Policy” is hereby amended to add the following new provision.

8. If this Policy terminates due to nonpayment of premium, the Policyholder may be eligible for reinstatement in the sole discretion of the Company, provided certain conditions are met. The following items are required to be submitted for reinstatement to be considered.

- a. Payment via cashier’s check for all premiums due;
- b. Payment via cashier’s check of a non-refundable reinstatement application fee in the amount of \$350 (or such other amount as may be deemed by Arkansas Blue Cross to cover reinstatement processing); and
- c. Completion and return of a signed group application for reinstatement.

A reinstatement request, together with the above requirements must be submitted within fifteen (15) days of the date on the “confirmation of termination” letter. The reinstatement request will then be forwarded to a designated underwriter for review. Following review (which the Company will attempt to complete on most applications within 3-5 business days), the Policyholder will be notified of the decision regarding the reinstatement request.

GENERAL PROVISIONS, “Refund of Premiums” is hereby amended to read as follows.

I. Refund of Premiums

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If the Employer terminates coverage of a Covered Person, the Company shall refund premium payments applicable to periods after the effective date of termination, provided that the Employer can demonstrate that the Covered Person made no contribution to such premium payments. The Employer must request the Company refund premiums paid for such Covered Person’s coverage within 60 days from the effective date of termination of such coverage. Failure of the Employer to make a refund request within 60 days of the effective date of termination of the Covered Person’s coverage shall result in the Employer waiving refund of any premiums paid for such coverage. If claims have been paid past the termination date, the payment amount of the claims will be deducted from premium refunds.

GENERAL PROVISIONS, “BlueCard” is hereby amended to read as follows.

P. Out-of-Arkansas Services

The Company has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Covered Persons access healthcare services outside the geographic area the Company serves, the State of Arkansas, the claim for those services may be processed through one of these Inter-Plan Programs and presented to the Company for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Covered Persons under this contract are described generally below.

Typically, Covered Persons, when accessing care outside the geographic area The Company serves, 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, Covered Persons may obtain care from non-participating healthcare providers. [Our/Licensee Name] payment practices in both instances are described below.

1. BlueCard® Program

Under the BlueCard® Program, when Covered Persons access covered healthcare services within the geographic area served by a Host Blue, the Company will remain responsible to you for fulfilling our contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

2. Liability Calculation Method Per Claim

- a. The calculation of the Covered Person liability on claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the participating healthcare provider's billed covered charges or the negotiated price made available to the Company by the Host Blue.
- b. Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare provider contracts. The negotiated price made available to the Company by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:
 - (i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or
 - (ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or
 - (iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.
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the price submitted by a Host Blue to the Company is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

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3. Return of Overpayments

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4. **Non-Participating Healthcare Providers Outside Arkansas Blue Cross and Blue Shield Service Area**

a. Covered Person Liability Calculation

When covered healthcare services are provided outside of the Company's service area by non-participating healthcare providers, the amount(s) a Covered Person pays 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, the Covered Person may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment the Company will make for the covered services as set forth in this paragraph.

b. Exceptions

In some exception cases, the Company may pay claims from non-participating healthcare providers outside of the Company's service area based on the provider's billed charge, such as in situations where an Covered Person did not have reasonable access to a participating provider, as determined by the Company in our sole and absolute discretion or by applicable state law. In other exception cases, we may pay such a claim based on the payment we would make if the Company were paying a non-participating provider inside of our service area, as described elsewhere in this contract, where the Host Blue's corresponding payment would be more than the Company's in-service area non-participating provider payment, or in our sole and absolute discretion, we may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Covered Person may be responsible for the difference between the amount that the non-participating healthcare provider bills and payment the Company will make for the covered services as set forth in this paragraph.

This Amendment shall become part of the Group Policy, and all provisions of the Group Policy not in conflict herewith remain in full force and effect.



P. Mark White, President and Chief Executive Officer

Arkansas Blue Cross and Blue Shield
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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: See attached. Attachment: Flesch Certification Form 23-2607, 23-2608, 23-2609 GMC 8-11.pdf	Approved-Closed	09/15/2011

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: Not needed. Comments:	Approved-Closed	09/15/2011

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary Bypass Reason: Not PPACA related. Comments:	Approved-Closed	09/15/2011



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

**RE: Arkansas Blue Cross and Blue Shield
Amendment Nos. 23-2607,23-2608, 23-2609 8/11**

**FLESCH READING EASE
CERTIFICATION**

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

Name

Vice President
Title

September 13, 2011
Date