

SERFF Tracking Number: HLAD-127623326 State: Arkansas
Filing Company: HMO Partners, Inc. d/b/a Health Advantage State Tracking Number: 49769
Company Tracking Number: 34-128 8/11
TOI: HOrg02G Group Health Organizations - Health Sub-TOI: HOrg02G.002C Any Size Group - HMO
Maintenance (HMO)
Product Name: Amendments
Project Name/Number: GEC/34-128 8/11

Filing at a Glance

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

Product Name: Amendments

SERFF Tr Num: HLAD-127623326 State: Arkansas

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

SERFF Status: Closed-Approved-
Closed State Tr Num: 49769

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

Co Tr Num: 34-128 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: GEC

Status of Filing in Domicile: Pending

Project Number: 34-128 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 form 34-128 8/11 for your review and approval if indicated.

This document adds language to administer Medical Loss Ratio rebates, amend the rescission provision and adds

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mandated Blue Cross and Blue Association language.

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 to which this amendment is attached. Please feel free to contact me at 378-2967 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:	\$50.00
Retaliatory?	No
Fee Explanation:	\$50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
HMO Partners, Inc. d/b/a Health Advantage	\$50.00	09/13/2011	51532750

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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	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes

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Form Schedule

Lead Form Number: 34-128 8/11

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/15/2011	34-128 8/11	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Amendment	Initial		40.600	34-128 8-11 GEC Amendment.p df



The Health Advantage Group Enrollment Contract, Form #30-01, and 30-02 are hereby amended.

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

Group to Distribute and Account for Premium Rebates

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

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

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

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

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

Group will indemnify Health Advantage in the event Health Advantage suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligations under this Section 2.10 of the Group Contract.

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

Right of Rescission

Fraud or intentional misrepresentation of material fact(s) may be used by Health Advantage as the basis for rescission of coverage of the Contract Holder, any Subscriber or any Dependent.

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

7. If this Contract terminates due to nonpayment of premium, the Group may be eligible for reinstatement in the sole discretion of Health Advantage, 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 Health Advantage 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 Health Advantage will attempt to complete on most applications within 3-5 business days), the Group will be notified of the decision regarding the reinstatement request.

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

Refund of Premiums

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

If the Employer terminates coverage of a Member, Health Advantage shall refund premium payments applicable to periods after the effective date of termination, provided that the Employer can demonstrate that the Member made no contribution to such premium payments. The Employer must request Health Advantage refund premiums paid for such Member’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 Member’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, Subsection 4.20 is hereby amended to read as follows.

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

Typically, Members, when accessing care outside the geographic area Health Advantage 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, Members may obtain care from non-participating healthcare providers. Health Advantage payment practices in both instances are described below.

Health Advantage covers only limited healthcare services received outside of our service area. As used in this subsection, 4.20 “Out-of-Arkansas Covered Healthcare Services” include for example, 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 Member’s primary care physician (“PCP”).

1. **BlueCard[®] Program**

Under the BlueCard[®] Program, when Members access covered healthcare services within the geographic area served by a Host Blue, Health Advantage will remain responsible to you for fulfilling Health Advantage’s 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.

a. **Liability Calculation Method Per Claim**

The calculation of the Member liability on claims for covered healthcare services processed through the BlueCard Program, if not a flat dollar copayment, will be based on the lower of the healthcare provider’s billed covered charges or the negotiated price made available to Health Advantage by the Host Blue.

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 Health Advantage 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.

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 Member 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 Health Advantage is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either (i) to use a basis for determining Member 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, Health Advantage would then calculate Member liability in accordance with applicable law.

b. 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.

2. Non-Participating Healthcare Providers Outside Health Advantage's Service Area

a. Member Liability Calculation

When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating healthcare

provider bills and the payment Health Advantage will make for the covered services as set forth in this paragraph.

b. **Exceptions**

In some exception cases, Health Advantage may pay claims from nonparticipating healthcare providers for Out-of Area Covered Healthcare Services based on the provider's billed charge, such as in situations where a Member did not have reasonable access to a participating provider, as determined by Health Advantage 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 Health Advantage were paying a non-participating provider for the same covered healthcare services inside of Health Advantage's service area, as described elsewhere in this contract where the Host Blue's corresponding payment would be more than Health Advantage'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 Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment Health Advantage will make for the covered services as set forth in this paragraph.

This amendment becomes a part of the Health Advantage Group Enrollment Contract. All provisions of the Group Enrollment Contract 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

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: See attached. Attachment: Flesch Certification Form HA, 34-128 8-11.pdf	Approved-Closed	09/15/2011
Bypassed - Item: Application Bypass Reason: Not needed. Comments:	Approved-Closed	09/15/2011
Bypassed - Item: Health - Actuarial Justification Bypass Reason: Not needed. Comments:	Approved-Closed	09/15/2011
Bypassed - Item: PPACA Uniform Compliance Summary Bypass Reason: Not PPACA related. Comments:	Approved-Closed	09/15/2011

Health Advantage



An Independent Licensee of the Blue Cross and Blue Shield Association

**Re: HMO Partners, Inc. d/b/a Health Advantage
Form No. 34-128 8/11**

FLESCH READING EASE CERTIFICATION

This is to certify that the above referenced document has achieved a Flesch Reading Ease Score average of 40.6 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

September 13, 2011

Date