

SERFF Tracking Number: ARBB-127129447 State: Arkansas  
 Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 48510  
 Company Tracking Number:  
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)  
 Product Name: Amendments  
 Project Name/Number: General Amendments/23-2593 7/11, 23-2594 7/11, 23-2192 R7/11,23-2301 R7/11, 23-2515 R7/11 23-2527 R7/11

## Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: Amendments

SERFF Tr Num: ARBB-127129447 State: Arkansas

TOI: H16I Individual Health - Major Medical

SERFF Status: Closed-Approved- Closed State Tr Num: 48510

Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)

Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Author: Evelyn Laney

Reviewer(s): Rosalind Minor

Date Submitted: 04/15/2011

Disposition Date: 04/26/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: General Amendments

Status of Filing in Domicile: Pending

Project Number: 23-2593 7/11, 23-2594 7/11, 23-2192 R7/11,23-2301 R7/11, 23-2515 R7/11 23-2527 R7/11

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Arkansas is state of domicile.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type: Individual

Overall Rate Impact:

Filing Status Changed: 04/26/2011

State Status Changed: 04/26/2011

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 23-2593, 2594 7/11, 23-2192 R7/11, 23-2301, R7/11, 23-2515 R7/11 and 23-2527 R7/11 for your review and approval if indicated.

Form 23-2527 R7/11 has been amended to delete the exclusion for eating disorders. This should have been done prior to the form original submission but was inadvertently left in the form. We do not deny coverage for eating disorders.

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Form 2593 and 2594 7/11 are general amendment for all individual business. We are clarifying the benefit for services provided by 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. This information is in the maternity riders for individual policies (forms 23-2192, 23-2301 and 23-2515 R7/11). We are deleting 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 Blue Cross and Blue Shield Association 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 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

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$300.00  
Retaliatory? No  
Fee Explanation: \$50.00 per form  
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Arkansas Blue Cross and Blue Shield	\$300.00	04/15/2011	46615202

SERFF Tracking Number: ARBB-127129447 State: Arkansas  
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 TOI: H161 Individual Health - Major Medical Sub-TOI: H161.005A Individual - Preferred Provider (PPO)  
 Product Name: Amendments  
 Project Name/Number: General Amendments/23-2593 7/11, 23-2594 7/11, 23-2192 R7/11,23-2301 R7/11, 23-2515 R7/11 23-2527 R7/11

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/26/2011	04/26/2011
Approved-Closed	Rosalind Minor	04/18/2011	04/18/2011

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Amendment	Christi Kittler	04/26/2011	04/26/2011

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Please re-open filing	Note To Reviewer	Christi Kittler	04/25/2011	04/25/2011

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## Disposition

Disposition Date: 04/26/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

This submission was re opened in order for your to replace Form 23-2594. Effective on this date, Form 23-2594 is approved.

The remainder of the forms will maintain the original approval date of 4/18/11.

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	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form (revised)	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Replaced	Yes

SERFF Tracking Number: ARBB-127129447 State: Arkansas  
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## Disposition

Disposition Date: 04/18/2011

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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Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form (revised)	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Replaced	Yes

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**Amendment Letter**

Submitted Date: 04/26/2011

**Comments:**

23-2594 did not have the BlueCard language on it and it should have.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
23-2594 7/11	Certificate Amendment, Insert Page, Endorsement or Rider	Amendment Initial					40.600	23-2594 7-11(Ind )Open-Closed.pdf

*SERFF Tracking Number:* ARBB-127129447 *State:* Arkansas  
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**Note To Reviewer**

**Created By:**

Christi Kittler on 04/25/2011 02:15 PM

**Last Edited By:**

Christi Kittler

**Submitted On:**

04/25/2011 02:15 PM

**Subject:**

Please re-open filing

**Comments:**

Please re-open filing as we did not include the BlueCard Program change in the original document.

Thanks so much!

Christi Kittler

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## Form Schedule

### Lead Form Number: 23-2593 7/11

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/18/2011	23-2593 7/11	Certificate Amendment	Amendment t, Insert Page, Endorsement or Rider	Initial		40.600	23-2593 7-11(Ind ).pdf
Approved-Closed 04/26/2011	23-2594 7/11	Certificate Amendment	Amendment t, Insert Page, Endorsement or Rider	Initial		40.600	23-2594 7-11(Ind )Open-Closed.pdf
Approved-Closed 04/18/2011	23-2192 R7/11	Certificate Amendment	Amendment t, Insert Page, Endorsement or Rider	Revised	Replaced Form #: 23-2192 R1/09 Previous Filing #: 23-2192 R1/09	40.600	23-2192 R7-11MatInd.pdf
Approved-Closed 04/18/2011	23-2301 R7/11	Certificate Amendment	Amendment t, Insert Page, Endorsement or Rider	Revised	Replaced Form #: 23-2301 R1/09 Previous Filing #: 23-2301 R1/09	40.600	23-2301 R7-11Maternity Rider New.pdf
Approved-Closed 04/18/2011	23-2515 R7/11	Certificate Amendment	Amendment t, Insert Page, Endorsement or Rider	Revised	Replaced Form #: 23-2515 7/09 Previous Filing #: 23-2515 7/09		23-2515 R7-11 Maternity Rider.pdf





**AMENDMENT TO THE  
ARKANSAS BLUE CROSS AND BLUE SHIELD  
COMPREHENSIVE MAJOR MEDICAL  
INDIVIDUAL POLICY**

**AMENDMENT NO. 2593  
GENERAL AMENDMENT  
Form Nos. 236,237,238,247,258,259,260,262,272,273,274,275,276**

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 Policy, 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.<sup>1]</sup>

**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 Policy, trans-telephonic home spirometry is covered for patients who have had a lung transplant.

**SPECIFIC PLAN EXCLUSIONS, Health Interventions, “Cerebellar Stimulator/Pacemaker”, “Cervicography”, “Dermatomal 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 Subsection 9.11. However, subject to all terms, conditions, exclusions and limitation of the Plan as set forth in this Policy, coverage is provided for Neurologic Rehabilitation Facility Services for Covered Persons with Severe Traumatic Brain Injury. See Subsection 3.[31].<sup>2]</sup>

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<sup>1</sup> This will only populate for packages with Maternity benefits.

<sup>2</sup> This will only apply to 17-258 – 17-276

**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 Policy, 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 Covered Person’s blood or tissue to determine if the Covered Person 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 Policy, a limited number of specific genetic tests may be covered for situations (4) or (5) referenced above when the Company 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. The Company 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 Arkansas Blue Cross 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 Diskectomy”** is hereby amended to read as follows.

Percutaneous diskectomy and Radio-frequency Thermocoagulation. Any method of percutaneous diskectomy, including, but not limited to, automated or manual percutaneous diskectomy, laser diskectomy, 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. <sup>3]</sup>

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<sup>3</sup> This will only populate for coverage with Maternity benefits.

**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 Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain healthcare services outside of the State of Arkansas (“our service area”), the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees. 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 nonparticipating healthcare providers. Our payment practices in both instances are described below.

a. **BlueCard® Program.**

- i. Under the BlueCard® Program, when you access 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. 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 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.
- ii. 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.
- iii. 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.
- iv. 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.

b. **Non-Participating Healthcare Providers Outside Our Service Area**

- i. When covered healthcare services are provided outside of our service area by non-participating healthcare providers, the amount you pay 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, 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 paragraph.**
- ii. In certain situations, we may use other payment bases, such as 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 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 paragraph.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Policy. All other provisions of the Policy remain in full force and effect.

*P. Mark White*

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P. Mark White, President and Chief Executive Officer

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



**AMENDMENT TO THE  
ARKANSAS BLUE CROSS AND BLUE SHIELD  
COMPREHENSIVE MAJOR MEDICAL  
INDIVIDUAL POLICY**

**AMENDMENT NO. 2594  
GENERAL AMENDMENT  
Form Nos. 69,70,93,108,111,113,125,126,129,130,134,135,141,147  
148,166,183,184,213,231,277**

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

**SERVICES NOT INCLUDED**, "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 Covered Person's blood or tissue to determine if the Covered Person 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 Benefit Policy, a limited number of specific genetic tests may be covered for situations (4) or (5) referenced above when the Company 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. The Company 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 Arkansas Blue Cross Coverage Policy regarding a genetic test will control whether or not benefits are available for that genetic test as an exception to this exclusion.

**OTHER PROVISIONS**, "Out of Arkansas Claims," 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 Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of the State of Arkansas ("our service area"), the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees. 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 nonparticipating healthcare providers. Our payment practices in both instances are described below.

1. **BlueCard® Program.**

- a. Under the BlueCard® Program, when you access 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. 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 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.

- b. 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.
  - c. 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.
  - d. 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.
2. **Non-Participating Healthcare Providers Outside Our Service Area**
- a. When covered healthcare services are provided outside of our service area by non-participating healthcare providers, the amount you pay 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, 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 paragraph.**
  - b. In certain situations, we may use other payment bases, such as 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 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 paragraph.

**SERVICES NOT INCLUDED** “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 Benefit Policy, coverage is provided for compression garments specifically designed to treat severe burns or compression sleeves and gloves used to treat lymphedemas following mastectomy.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Policy. All other provisions of the Policy remain in full force and effect.



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P. Mark White, President and Chief Executive Officer

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



**AMENDMENT TO THE  
ARKANSAS BLUE CROSS AND BLUE SHIELD  
COMPREHENSIVE MAJOR MEDICAL  
INSURANCE POLICY**

**AMENDMENT NO. 2192  
MATERNITY BENEFITS  
Form Nos. 236, 237, 238**

**TABLE OF CONTENTS**, Subsection 3.25 Testing of Newborn Children is hereby amended to read as follows.

**Pre-Natal Test and Testing of Newborn Children**

**TABLE OF CONTENTS**, is hereby amended to add the following new Subsection in 3.0 BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN.

**Maternity**

**BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN**, Subsection 3.25 Testing of Newborn Children, is hereby amended to read as follows.

**Pre-Natal Tests and Testing of Newborn Children.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy coverage is provided for pre-natal tests and tests of newborn children that are supported by Coverage Policy. Examples of such tests that are covered include testing for Down's syndrome, hypothyroidism, sickle-cell anemia, phenylketonuria/galactosemia, (PKU) and other disorders of metabolism. This benefit is subject to the Deductible and Coinsurance specified in the Schedule of Benefits.

**BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN**, is hereby amended to add the following new Subsection.

**Maternity.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for maternity care when performed or prescribed by a Physician subject to the Deductible and Coinsurance amounts specified in the Schedule of Benefits.

1. **Maternity and Obstetrical Care.** Coverage is provided for Maternity and Obstetrical Care, including Routine Prenatal Care and postnatal care; and use of Hospital delivery rooms and related facilities; special procedures as may be necessary. Routine Prenatal Care includes the coverage of one routine ultrasound only. See Subsection 4.3.76 concerning exclusion of additional routine ultrasounds.
2. **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 Policy, 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.
3. **Newborn Care in the Hospital.** The Policyholder's or Spouse's newborn child will be covered from the date of birth, including use of newborn nursery (for up to five (5) days or until the mother is discharged, whichever is the lesser period of time) and related services, provided the child's coverage becomes effective on his or her date of birth in accordance with the provisions of Section 6.0.
4. **Allowable Charges for In Vitro Fertilization and Infertility.** Subject to other limitations found herein, Coverage is provided for Allowable Charges for in vitro

fertilization and infertility provided:

- a. The patient is the Policyholder or is a covered Spouse of the Policyholder; and
- b. The following facts are medically documented:
  - i. the patient and the patient's Spouse have a history of unexplained Infertility of at least two (2) years duration; or
  - ii. the infertility is associated with one or more of the following medical conditions:
    - (1) endometriosis;
    - (2) exposure in utero to Diethylstilbestrol (DES);
    - (3) blockage of or removal of one or both fallopian tubes not a result of voluntary sterilization;
    - (4) abnormal male factors contributing to such infertility not a result of voluntary sterilization.
- c. The patient's oocytes must be fertilized with the sperm of the patient's Spouse when any fertilization procedures are performed.
- d. In vitro fertilization procedures must be performed at a facility licensed by the Arkansas Department of Health as an in vitro fertilization clinic, or if such licensed clinic is unavailable, in a clinic elsewhere which is approved by the Company.
- e. The lifetime maximum benefits available under this Policy for all approved infertility Allowable Charges, including in vitro fertilization, all drug therapy, and any other services related to infertility shall not exceed the sum of Fifteen Thousand Dollars (\$15,000). **No benefits for infertility or in vitro fertilization are available if either party has previously undergone a voluntary sterilization.**
- f. Services related to the reversal of any sterilization procedure regardless of the reason for the sterilization are not covered.

5. **Genetic Testing.**

- a. Services for genetic testing to determine the likelihood of developing a disease or condition, the likelihood of a disease or the presence of a disease in a relative, or the likelihood of passing an inheritable disease or congenital abnormality to an offspring, are not covered.
- b. Services for pre-implantation genetic diagnosis or treatment are not covered.
- c. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Policy, genetic testing of the products of an amniocentesis, to determine the presence of a disease or congenital anomaly in the fetus, or genetic testing of a Covered Person's tissue to determine if the Covered Person has a specific disease (not to determine if the person is a carrier of a genetic abnormality), is covered. See Subsection 3.25 dealing with Pre-Natal Tests.

**SPECIFIC PLAN EXCLUSIONS**, "Maternity Care and Obstetrical Care," is hereby deleted in its entirety.

**SPECIFIC PLAN EXCLUSIONS**, Subsection 4.3 is hereby amended to add a new Subsection to read as follows.

Ultrasounds. More than one basic level obstetrical ultrasound during Routine Prenatal Care is not covered.

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

**GLOSSARY OF TERMS**, is hereby amended to add a new Subsection to read as follows.

**Routine Prenatal Care** means outpatient antepartum care and laboratory testing that has been approved as routine based on a Coverage Policy established by the Company. A copy of the Routine Prenatal Care Coverage Policy is available from the Company, at no cost, upon request, or may be reviewed on the Company's web site at [WWW.ARKANSASBLUECROSS.COM](http://WWW.ARKANSASBLUECROSS.COM).

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Insurance Policy. All other provisions of the Insurance Policy remain in full force and effect.



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P. Mark White, Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD  
A MUTUAL INSURANCE COMPANY  
601 S. Gaines Street  
Little Rock, Arkansas 72201



**AMENDMENT TO THE  
ARKANSAS BLUE CROSS AND BLUE SHIELD  
BLUECHOICE® COMPREHENSIVE MAJOR  
MEDICAL INDIVIDUAL INSURANCE POLICY**

**AMENDMENT NO. 2301**

**\$5,000 MATERNITY BENEFIT  
12-Month Waiting Period**

**BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN**, provision 3.25 is hereby amended to read as follows.

**Prenatal Tests and Testing of Newborn Children.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy coverage is provided for pre-natal tests and tests of newborn children that are supported by Coverage Policy. Examples of such tests that are covered include testing for Down's syndrome, hypothyroidism, sickle-cell anemia, phenylketonuria/galactosemia, (PKU) and other disorders of metabolism. This benefit is subject to the Coinsurance specified in the Schedule of Benefits and is further limited to the aggregate maximum of \$5,000 per pregnancy.

**BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN**, is hereby amended to add the following new Subsection.

**Maternity.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for maternity care when performed or prescribed by a Physician, subject to the Coinsurance amounts specified in the Schedule of Benefits and further limited to the aggregate maximum of \$5,000 per pregnancy.

1. **Maternity and Obstetrical Care.** Coverage is provided for Maternity and Obstetrical Care, including Routine Prenatal Care and postnatal care; and use of Hospital delivery rooms and related facilities; special procedures as may be necessary. Routine Prenatal Care includes the coverage of one routine ultrasound only. See Subsection 4.3.77 concerning exclusion of additional routine ultrasounds.
2. **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 Policy, 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.
3. **Newborn Care in the Hospital.** A Policyholder's or Spouse's newborn child will be covered from the date of birth, including use of newborn nursery (for up to five (5) days or until the mother is discharged, whichever is the lesser period of time) and related services, provided the child's coverage becomes effective on his or her date of birth in accordance with the provisions of Section 6.0 of the Policy. If the Policyholder is covered by an individual only Policy on the date the Child is born or if the Policyholder on a family Policy fails to give notice of the Child's birth within 90 days of the Child's date of birth, coverage of the newborn Child is subject to the Company's approval through the Company's underwriting standards after the Child's two-month check-up. This means that there is no possibility of a newborn Child obtaining coverage from such Child's date of birth unless this Policy covers the Policyholder AND members of the Policyholder's family prior to the pregnancy.
4. **Allowable Charges for In Vitro Fertilization and Infertility.** Subject to other limitations found herein, Coverage is provided for Allowable Charges for in vitro fertilization and infertility provided:
  - a. The patient is the Policyholder or is a covered Spouse of the Policyholder; and

- b. The following facts are medically documented:
    - i. the patient and the patient's Spouse have a history of unexplained Infertility of at least two (2) years duration; or
    - ii. the infertility is associated with one or more of the following medical conditions:
      - (1) endometriosis;
      - (2) exposure in utero to Diethylstilbestrol (DES);
      - (3) blockage of or removal of one or both fallopian tubes not a result of voluntary sterilization;
      - (4) abnormal male factors contributing to such infertility not a result of voluntary sterilization.
  - c. The patient's oocytes must be fertilized with the sperm of the patient's Spouse when any fertilization procedures are performed.
  - d. In vitro fertilization procedures must be performed at a facility licensed by the Arkansas Department of Health as an in vitro fertilization clinic, or if such licensed clinic is unavailable, in a clinic elsewhere which is approved by the Company.
  - e. The lifetime maximum benefits available under this Policy for all approved infertility Allowable Charges, including in vitro fertilization, all drug therapy, and any other services related to infertility shall not exceed the sum of Fifteen Thousand Dollars (\$15,000). **No infertility related Allowable Charges or in vitro fertilization benefits are available to either the husband or the wife, whether covered under this Policy or not, when either one of the Spouses has previously undergone a voluntary sterilization.**
  - f. Services related to the reversal of any sterilization procedure regardless of the reason for the sterilization are not covered.
5. **Genetic Testing.**
- a. Services for genetic testing to determine the likelihood of developing a disease or condition, the likelihood of a disease or the presence of a disease in a relative, or the likelihood of passing an inheritable disease or congenital abnormality to an offspring, are not covered.
  - b. Services for pre-implantation genetic diagnosis or treatment are not covered.
  - c. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in the Policy, genetic testing of the products of an amniocentesis, to determine the presence of a disease or congenital anomaly in the fetus, or genetic testing of a Covered Person's tissue to determine if the Covered Person has a specific disease (not to determine if the person is a carrier of a genetic abnormality), is covered. See Subsection 3.25 dealing with Pre-Natal Tests.

**SPECIFIC PLAN EXCLUSIONS**, "Maternity Care and Obstetrical Care," is hereby deleted in its entirety. All remaining Subsections are renumbered to correlate with the change.

**SPECIFIC PLAN EXCLUSIONS**, Subsection 4.3, Health Interventions is hereby amended to add the following new Subsection. All remaining Subsections are renumbered to correlate with the change.

Ultrasounds. More than one basic level obstetrical ultrasound during Routine Prenatal Care is not covered.

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

**PROVIDER NETWORK AND COST SHARING PROCEDURES**, Subsection 5.2.2.b. is hereby amended to add the following sentence.

No Allowable Charges paid for Maternity Care or Obstetrical Care shall accumulate to or be impacted by the satisfaction of the In-Network Calendar Year Coinsurance Maximum.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield BlueChoice Comprehensive Major Medical Individual Policy. All other provisions of the policy remain in full force and effect.



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P. Mark White, Chief Executive Officer

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



**AMENDMENT TO THE  
ARKANSAS BLUE CROSS AND BLUE SHIELD  
COMPREHENSIVE MAJOR MEDICAL  
INDIVIDUAL INSURANCE POLICY**

**AMENDMENT NO. 2515**

**MATERNITY BENEFIT  
12-Month Waiting Period**

**BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN**, "Testing of Newborn Children" is hereby amended to read as follows.

**Prenatal Tests and Testing of Newborn Children.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy coverage is provided for prenatal tests and tests of newborn children that are supported by Coverage Policy. Examples of such tests that are covered include testing for Down's syndrome, hypothyroidism, sickle-cell anemia, phenylketonuria/galactosemia, (PKU) and other disorders of metabolism. This benefit is subject to the Deductible and Coinsurance specified in the Schedule of Benefits.

**BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN**, is hereby amended to add the following new Subsection.

**Maternity.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for maternity care when performed or prescribed by a Physician, subject to the Deductible and Coinsurance amounts specified in the Schedule of Benefits.

1. **Maternity and Obstetrical Care.** Coverage is provided for Maternity and Obstetrical Care, including Routine Prenatal Care and postnatal care; and use of Hospital delivery rooms and related facilities; special procedures as may be necessary. Routine Prenatal Care includes the coverage of one routine ultrasound only. See Subsection 4.3 concerning exclusion of additional routine ultrasounds.
2. **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 Policy, 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.
3. **Newborn Care in the Hospital.** A Policyholder's or Spouse's newborn child will be covered from the date of birth, including use of newborn nursery (for up to five (5) days or until the mother is discharged, whichever is the lesser period of time) and related services, provided the child's coverage becomes effective on his or her date of birth in accordance with the provisions of Section 6.0 of the Policy. If the Policyholder fails to give notice of the Child's birth within 90 days of the Child's date of birth, coverage of the newborn Child is subject to the Company's approval through the Company's underwriting standards after the Child's two-month check-up.
4. **Allowable Charges for In Vitro Fertilization and Infertility.** Subject to other limitations found herein, Coverage is provided for Allowable Charges for in vitro fertilization and infertility provided:
  - a. The patient is the Policyholder or is a covered Spouse of the Policyholder; and
  - b. The following facts are medically documented:
    - i. the patient and the patient's Spouse have a history of unexplained Infertility of at least two (2) years duration; or
    - ii. the infertility is associated with one or more of the following medical conditions:
      - (1) endometriosis;

- (2) exposure in utero to Diethylstilbestrol (DES);
    - (3) blockage of or removal of one or both fallopian tubes not a result of voluntary sterilization;
    - (4) abnormal male factors contributing to such infertility not a result of voluntary sterilization.
  - c. The patient's oocytes must be fertilized with the sperm of the patient's Spouse when any fertilization procedures are performed.
  - d. In vitro fertilization procedures must be performed at a facility licensed by the Arkansas Department of Health as an in vitro fertilization clinic, or if such licensed clinic is unavailable, in a clinic elsewhere which is approved by the Company.
  - e. The lifetime maximum benefits available under this Policy for all approved infertility Allowable Charges, including in vitro fertilization, all drug therapy, and any other services related to infertility shall not exceed the sum of Fifteen Thousand Dollars (\$15,000). **No infertility related Allowable Charges or in vitro fertilization benefits are available to either the husband or the wife, whether covered under this Policy or not, when either one of the Spouses has previously undergone a voluntary sterilization.**
  - f. Services related to the reversal of any sterilization procedure regardless of the reason for the sterilization are not covered.
5. **Genetic Testing.**
- a. Services for genetic testing to determine the likelihood of developing a disease or condition, the likelihood of a disease or the presence of a disease in a relative, or the likelihood of passing an inheritable disease or congenital abnormality to an offspring, are not covered.
  - b. Services for pre-implantation genetic diagnosis or treatment are not covered.
  - c. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in the Policy, genetic testing of the products of an amniocentesis, to determine the presence of a disease or congenital anomaly in the fetus, or genetic testing of a Covered Person's tissue to determine if the Covered Person has a specific disease (not to determine if the person is a carrier of a genetic abnormality), is covered. See Subsection 3.25 dealing with Prenatal Tests.

**SPECIFIC PLAN EXCLUSIONS**, "Maternity Care and Obstetrical Care" is hereby deleted in its entirety. All remaining Subsections are renumbered to correlate with the change.

**SPECIFIC PLAN EXCLUSIONS**, Subsection 4.3, Health Interventions is hereby amended to add the following new Subsection. All remaining Subsections are renumbered to correlate with the change.

Ultrasounds. More than one basic level obstetrical ultrasound during Routine Prenatal Care is not covered.

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

**PROVIDER NETWORK AND COST SHARING PROCEDURES**, Subsection 5.2.2.b. is hereby amended to add the following sentence.

No Allowable Charges paid for Maternity Care or Obstetrical Care shall accumulate to or be impacted by the satisfaction of the In-Network Calendar Year Coinsurance Maximum.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Comprehensive Major Medical Individual Policy. All other provisions of the policy remain in full force and effect.

*P. Mark White*

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P. Mark White, President and Chief Executive Officer

ARKANSAS BLUE CROSS AND BLUE SHIELD  
A MUTUAL INSURANCE COMPANY  
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  
COMPREHENSIVE MAJOR MEDICAL INDIVIDUAL  
INSURANCE POLICY**

**AMENDMENT NO. 2527  
MENTAL HEALTH PARITY BENEFIT RIDER  
Form Nos. 259 & 262**

**OUTLINE OF COVERAGE, SPECIAL LIMITATIONS,** Psychiatric & Substance Abuse benefit maximum is hereby deleted in its entirety.

**BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Psychiatric Conditions and Substance Abuse Services** is hereby amended to read as follows.

**Mental Illness and Substance Abuse Services (Alcohol and Drug Abuse).** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for Health Interventions to treat Mental Illness and Substance Abuse.

1. **Outpatient Health Interventions.**
  - a. Coverage of Mental Illness and Substance Abuse Health Interventions during office visits and other forms of outpatient treatment, including partial or full-day program services is subject to the Specialty Care Physician Copayment and to the Deductible and Coinsurance set out in the Schedule of Benefits.
  - b. Coverage of office visits and other outpatient treatment sessions, beyond the eighth session in a calendar year, except for medication management treatment sessions, is subject to Prior Approval from the Company. See Subsection 3, below.
2. **Inpatient, Partial Hospitalization Program and Intensive Outpatient Program Health Interventions**
  - a. Coverage for Inpatient Hospitalization, Partial Hospitalization Programs or Intensive Outpatient Programs for Mental Illness or Substance Abuse Health Interventions is subject to Prior Approval from the Company. See Subsection 3 below.
    - i. Inpatient Hospitalization requires a patient to receive Covered Services 24 hours a day as an inpatient in a Hospital.
    - ii. Partial Hospitalization Programs generally require the patient to receive Covered Services six to eight hours a day, five to seven days per week in a Hospital.
    - iii. Intensive Outpatient Programs generally require the patient to receive Covered Services lasting two to four hours a day, three to five days per week in a Hospital.
  - b. Coverage is subject to the Deductible and Coinsurance set forth in the Schedule of Benefits.
  - c. **The treating facility must be a Hospital.** See Subsection 9.42. Treatment received at a Freestanding Residential Substance Abuse Treatment Center or at a Freestanding Psychiatric Residential Treatment Facility is not a covered benefit.
3. **Prior Approval.** Coverage for many Health Interventions for the treatment of Mental Illness and Substance Abuse are subject to Prior Approval from the Company. To request Prior Approval, please call the "Behavioral Health"

telephone number on your ID card. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished us at the time indicates that the proposed Health Intervention meets the Primary Coverage Criteria requirements set out in Subject 2.2 and the Applications of the Primary Care Criteria set out in Subsections 2.4.1.b, e., or f. All services, including any Health Interventions for the treatment of Mental Illness or Substance Abuse receiving Prior Approval may be limited or denied if, when the claims for the Health Intervention are received by us, investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or that any other basis for denial of the claim specified in this Policy exists.**

4. The following services and treatments are not covered.
  - a. **Group Therapy.** Group therapy or group counseling at any time in any setting by any Provider is not covered. See Subsection 4.3.36.
  - b. **Health and Behavior Assessment/Intervention.** Evaluation of psychosocial factors potentially impacting physical health problems and treatments are not covered. This includes health and behavior assessment procedures used to identify psychological, behavioral, emotional, cognitive, and social factors affecting physical health problems. See Subsection 4.3.38.
  - c. **Hypnotherapy.** Hypnotherapy is not covered for any diagnosis or medical condition. See 4.3.43.
  - d. **Marriage and Family Therapy.** Marriage and family therapy or counseling services are not covered. See Subsection 4.3.52.
  - e. **Sex Changes/Sex Therapy.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment or other treatment of sexual dysfunction including Prescription Medication and sex therapy. See Subsection 4.3.70.

**GLOSSARY OF TERMS, Psychiatric Conditions** is hereby deleted in its entirety.

**GLOSSARY OF TERMS** is hereby amended to add the following new Subsections. All remaining subsections are renumbered to correlate with the change.

**Mental Illness** means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include only illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)

**Substance Abuse** means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Policy. All other provisions of the Policy remain in full force and effect.

*P. Mark White*

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P. Mark White, President and Chief Executive Officer

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

*SERFF Tracking Number:* ARBB-127129447      *State:* Arkansas  
*Filing Company:* Arkansas Blue Cross and Blue Shield      *State Tracking Number:* 48510  
*Company Tracking Number:*  
*TOI:* H16I Individual Health - Major Medical      *Sub-TOI:* H16I.005A Individual - Preferred Provider  
(PPO)  
*Product Name:* Amendments  
*Project Name/Number:* General Amendments/23-2593 7/11, 23-2594 7/11, 23-2192 R7/11,23-2301 R7/11, 23-2515 R7/11 23-2527 R7/11

Rate data does NOT apply to filing.

SERFF Tracking Number: ARBB-127129447 State: Arkansas  
 Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 48510  
 Company Tracking Number:  
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)  
 Product Name: Amendments  
 Project Name/Number: General Amendments/23-2593 7/11, 23-2594 7/11, 23-2192 R7/11,23-2301 R7/11, 23-2515 R7/11 23-2527 R7/11

## Supporting Document Schedules

		Item Status:	Status Date:
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	04/18/2011
<b>Comments:</b>	See attached.		
<b>Attachment:</b>	Flesch Score 23-2593 7-11.pdf		
<b>Bypassed - Item:</b>	Application	Approved-Closed	04/18/2011
<b>Bypass Reason:</b>	Not needed for amendments.		
<b>Comments:</b>			
<b>Bypassed - Item:</b>	Health - Actuarial Justification	Approved-Closed	04/18/2011
<b>Bypass Reason:</b>	Not needed for amendments.		
<b>Comments:</b>			
<b>Bypassed - Item:</b>	Outline of Coverage	Approved-Closed	04/18/2011
<b>Bypass Reason:</b>	Not needed for amendments.		
<b>Comments:</b>			
<b>Bypassed - Item:</b>	PPACA Uniform Compliance Summary	Approved-Closed	04/18/2011
<b>Bypass Reason:</b>	Not PPACA related.		

*SERFF Tracking Number:* ARBB-127129447      *State:* Arkansas  
*Filing Company:* Arkansas Blue Cross and Blue Shield      *State Tracking Number:* 48510  
*Company Tracking Number:*  
*TOI:* H16I Individual Health - Major Medical      *Sub-TOI:* H16I.005A Individual - Preferred Provider  
(PPO)  
*Product Name:* Amendments  
*Project Name/Number:* General Amendments/23-2593 7/11, 23-2594 7/11, 23-2192 R7/11,23-2301 R7/11, 23-2515 R7/11 23-2527 R7/11

**Comments:**



# Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

**RE: Arkansas Blue Cross and Blue Shield  
Amendment Nos. 23-2593, 23-2594 7/11, 23-2192, 23-2301,23-2515,  
23-2527 R7/11**

## 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.

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Name

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Vice President

Title

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April 15, 2011

Date

SERFF Tracking Number: ARBB-127129447 State: Arkansas  
 Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 48510  
 Company Tracking Number:  
 TOI: H161 Individual Health - Major Medical Sub-TOI: H161.005A Individual - Preferred Provider  
 (PPO)  
 Product Name: Amendments  
 Project Name/Number: General Amendments/23-2593 7/11, 23-2594 7/11, 23-2192 R7/11,23-2301 R7/11, 23-2515 R7/11 23-2527 R7/11

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/15/2011	Form	Amendment	04/26/2011	23-2594 7-11(Ind.)Closed.pdf (Superseded)



**AMENDMENT TO THE  
ARKANSAS BLUE CROSS AND BLUE SHIELD  
COMPREHENSIVE MAJOR MEDICAL  
INDIVIDUAL POLICY**

**AMENDMENT NO. 2594  
GENERAL AMENDMENT  
Form Nos. 69,70,108,111,113,125,126,129,130,134,135,141,147  
148,166,183,184,213,231,277**

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

**SERVICES NOT INCLUDED**, "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 Covered Person's blood or tissue to determine if the Covered Person 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 Benefit Policy, a limited number of specific genetic tests may be covered for situations (4) or (5) referenced above when the Company 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. The Company 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 Arkansas Blue Cross Coverage Policy regarding a genetic test will control whether or not benefits are available for that genetic test as an exception to this exclusion.

**SERVICES NOT INCLUDED** "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 Benefit Policy, coverage is provided for compression garments specifically designed to treat severe burns or compression sleeves and gloves used to treat lymphedemas following mastectomy.

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Policy. All other provisions of the Policy remain in full force and effect.

*P. Mark White*

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P. Mark White, President and Chief Executive Officer

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