

State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: January 1, 2013 General Amendment - Individual
Project Name/Number: Amendment/23-2671 1/13

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield
Product Name: January 1, 2013 General Amendment - Individual
State: Arkansas
TOI: H16I Individual Health - Major Medical
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Filing Type: Form
Date Submitted: 11/06/2012
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SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: 23-2671 1/13

Implementation: 01/01/2013
Date Requested:
Author(s): Christi Kittler, Yvonne McNaughton, Frank Sewall, Rita Thatcher, Evelyn Laney
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 11/06/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

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General Information

Project Name: Amendment Status of Filing in Domicile: Pending
 Project Number: 23-2671 1/13 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: 11/06/2012
 State Status Changed: 11/06/2012
 Deemer Date: Created By: Evelyn Laney
 Submitted By: Evelyn Laney Corresponding Filing Tracking Number:
 PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Attached please find form 23-2671 1/13 for your review and approval if indicated.

Dental Care and Orthodontic Services

Generally, dental care and orthodontic services are not covered under the Plan. However, we are amending the provision to allow coverage for dental services in connection with radiation treatment for cancer of the head or neck where appropriate.

Organ Transplant Services

We are amending Plan language to clarify that we cover high-dose or non-myloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation only when supported by the Company's Coverage Policies relative to such conditions. This does not represent a change in benefit but a clarification only.

Influenza Vaccinations

We are modifying the provisions surrounding influenza vaccinations to clarify that coverage is subject to the Plans allowance for intradermally administered (shots) influenza vaccinations without thimerasol. Thimerasol a mercury-containing organic compound that has been widely used as a preservative in many vaccines since the 1930s. This does not represent a change in benefit but a clarification only.

Electrotherapy Stimulators

The exclusion for electrotherapy stimulators is being amended to reflect new coverage for neuromuscular electrical stimulation (NMES) when supported by Coverage Policy.

Sleep Apnea, Portable Studies

Generally, portable sleep apnea studies are not covered. However, we are modifying the Plan language to provide coverage for certain portable sleep apnea studies when certain criteria are met.

Vision Enhancement

The exclusion for vision enhancements is being amended to reflect new coverage for Keratoprosthesis (corneal implant). It was previously excluded.

Allowable Charge

We are amending the definition of Charge to clarify that we will pay each Current Procedural Terminology (CPT) code billed only one time. The CPT code is an all-inclusive, global payment that covers all elements of the service as described in the code and paid by the Health Plan. No further reimbursements are allowed. This does not represent a change in benefits. There were several technical clarifications made within these policies. Please refer to the amendment for these changes. Also enclosed is a Flesch Reading Ease score certification signed by an officer of the company as required by Arkansas Code Annotated §23-80-206(d). Please also note, we have scored the rider as part of the benefit certificates with which it will be used as provided by Arkansas Code Annotated §23-80-206(e).

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By way of this letter, I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19.

I certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 are incorporated in the benefit certificates to which this amendment will be attached.

I further certify that the consumer information notice required by Arkansas Code Annotated §23-79-138 is incorporated in the benefit certificates to which this amendment is 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:	\$50.00
Retaliatory?	No
Fee Explanation:	\$50.00
Per Company:	No

Company	Amount	Date Processed	Transaction #
Arkansas Blue Cross and Blue Shield	\$50.00	11/06/2012	64615994

SERFF Tracking #:

ARBB-128758403

State Tracking #:

Company Tracking #:

23-2671 1/13

State:

Arkansas

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/06/2012	11/06/2012

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Disposition

Disposition Date: 11/06/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	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

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Form Schedule

Lead Form Number: 23-2671 1/13

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/06/2012	Amendment	23-2671 1/13	CERA	Initial		40.100	23-2671 1-13 abcbs IndamdxPress.pdf

Form Type Legend:

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



**AMENDMENT NO. 2671
GENERAL AMENDMENT**

Form Nos. 236, 237, 238, 247, 258, 259, 260, 262, 272, 273, 274, 275, 276, 279

The following subsection amendments are effective on January 1, 2013.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, introductory paragraphs are hereby amended to read as follows.

[Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, we include coverage for such services or treatments but place limits on the extent of coverage, either by limiting the number of Provider visits or treatments, or by specifying a dollar limit for services or treatments received during a calendar year or other specified period of time. This Section 3.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the six coverage criteria, are satisfied. This Section 3.0 sets out specific limitations applicable to each covered medical service, drug, supply or equipment.

You will note references to Deductibles and Coinsurance obligations. This Policy contains three separate Deductibles depending on the type and site of service: Major Medical Services, Office-Based Services and Prescription Medications purchased at a retail pharmacy. For a description of the amount of these obligations and how they may vary depending upon the type and site of service and whether you select an In-Network or Out-of-Network Provider, refer to Section 5.0, the definition of Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.^{1]}

[Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, we include coverage for such services or treatments but place limits on the extent of coverage, either by limiting the number of Provider visits or treatments, or by specifying a dollar limit for services or treatments received during a calendar year or other specified period of time. This Section 3.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the six coverage criteria, are satisfied. This Section 3.0 sets out specific limitations applicable to each covered medical service, drug, supply or equipment.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of-Network Provider, refer to Section 5.0, the definition of Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.^{2]}

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Dental Care and Orthodontic Services" is hereby amended to read as follows.

[Dental Care and Orthodontic Services. Dental Care and orthodontic services are not covered. However, if a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, including the applicable Deductible and Coinsurance, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury with the following limitations:

¹ Applies to 17-258 and 17-272 only.

² Applies to all policies except 17-258 and 17-272.

1. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
3. This benefit is limited to the first twelve (12) months immediately following the Accidental Injury. If the Covered Person is under age 15, reimbursement for Dental Care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of the Company, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Covered Person is in force when the treatment is rendered.
4. Injury to teeth while eating is not considered an Accidental Injury.
5. Double abutments are not covered.
6. Any Health Intervention related to dental caries or tooth decay is not covered.
7. Removal of impacted teeth is not covered.
8. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

Dental services in connection with radiation treatment for cancer of the head or neck are covered.

Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures are generally not covered. However, some services may be covered in accordance with Subsection 3.2.3.^{3]}

[Dental Care and Orthodontic Services. Dental Care and orthodontic services are not covered. However, if a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury with the following limitations:

1. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
3. This benefit is limited to the first twelve (12) months immediately following the Accidental Injury. If the Covered Person is under age 15, reimbursement for Dental Care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of the Company, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Covered Person is in force when the treatment is rendered.
4. Injury to teeth while eating is not considered an Accidental Injury.
5. Double abutments are not covered.
6. Any Health Intervention related to dental caries or tooth decay is not covered.
7. Removal of impacted teeth is not covered.
8. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

Dental services in connection with radiation treatment for cancer of the head or neck are covered.

³ Applies to 12-258 and 17-272 only.

Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures are generally not covered. However, some services may be covered in accordance with Subsection 3.2.3.^{4]}

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Organ Transplant Services" Subsections 7-9 are hereby amended to read as follows.

7. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to the Company's specific Coverage Policies relative to these specific conditions.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Children's Preventive Services" Subsection 4 is hereby amended to read as follows.

[Benefits for Evaluation and Management Office Visits and recommended immunization services shall be exempt from any copayment, Coinsurance, Deductible or dollar limit provisions. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.^{5]}

[The Company will pay one hundred percent (100%) of Allowable Charges for children's preventive health care services, or the amounts established by the Arkansas Insurance Commissioner as the reimbursement levels for these services, whichever is greater. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.^{6]}

[The Company will pay one hundred percent (100%) of Allowable Charges for children's preventive health care services, or the amounts established by the Arkansas Insurance Commissioner as the reimbursement levels for these services, whichever is greater. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Benefit Period.^{7]}

[Subject to the Covered Person's payment of the Deductible and the appropriate Coinsurance set forth in the Schedule of Benefits, the Company will pay the percentage set forth on the Schedule of Benefits of Allowable Charges for children's preventive health care services, or the amounts established by the Arkansas Insurance Commissioner as the reimbursement levels for these services, whichever is greater. Benefits for Evaluation and Management Office Visits and recommended immunization services shall be exempt from any copayment, Coinsurance, Deductible or dollar limit provisions. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per Calendar Year.]

[BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Wellness Benefits is hereby amended to read as follows.

Essential Wellness Benefits. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy (with the exception of Subsection 2.2.1), the Company will pay one hundred percent (100%) of the Allowable Charges for the Essential Wellness Benefits listed below when provided by a Primary Care Physician or an advanced practice nurse or physician's assistant who provides primary medical care in the areas of general practice, pediatrics, family

⁴ Applies to all policies except 17-258 and 17-272

⁵ Applies to 17-258

⁶ Applies to 17-272, 17-273, 17-274, 17-275 and 17-276

⁷ Applies to 17-279 only

practice, internal medicine or obstetrics/gynecology, which are performed in the Primary Care Physician's office. However, for services received by Non-Preferred Provider Physicians, the Company will pay eighty percent (80%) subject to the Deductible and Coinsurance stated in the Schedule of Benefits. Essential Wellness Benefits include the following:

1. Exams and Evaluations
 - a. Counseling related to BRCA screening for breast & ovarian cancer susceptibility, genetic risk assessment and BRCA mutation testing; limited to one (1) per Benefit Period.
 - b. Counseling for chemoprevention of breast cancer;
 - c. Screening for depression (adults and children 12-18 years of age limited to one per Benefit Period);
 - d. Screening for children and adults patients six (6) years of age and older for obesity and intensive counseling and behavioral interventions to promote sustained weight loss; Limited to 12 (twelve) counseling sessions per Benefit Period.
 - e. High intensity behavioral counseling for sexually transmitted infections; Limited to six (6) counseling sessions per Benefit Period.
 - f. Counseling for tobacco use and tobacco cessation;
 - g. Women's annual preventive services visits including pelvic examinations and PAP smears; routine mammography for women over 40 years of age and older; and
 - h. Initial periodic and comprehensive annual general preventive medical exams and recommended vaccines; Zoster (shingles) vaccine covered for patients 60 years of age and older.
2. Screening labs
 - a. Asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit;
 - b. Chlamydial infection screening for women. Limited to two (2) per Benefit Period;
 - c. Diabetes mellitus, type 2, screening, in asymptomatic adults with sustained blood pressure; Limited to one (1) per Benefit Period.
 - d. Gonorrhea, screening for all sexually active women, including those who are pregnant;
 - e. Gonorrhea, prophylactic medication, provide prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum;
 - f. Hepatitis B virus infection, screening for in pregnant women at their first prenatal visit;
 - g. Human immunodeficiency virus, screening, all adolescents and adults at increased risk for HIV infection; Limited to two (2) per Benefit Period.
 - h. Lipid disorders, screening (20 years of age and older); Limited to one per Benefit Period
 - i. Phenylketonuria, screening;
 - j. Rh (D) incompatibility and Rh (D) antibody testing; Limited to two (2) per Benefit Period
 - l. Sickle cell disease, screening, in newborns;
 - m. Syphilis, screening for persons at increased risk; and all pregnant women
 - n. Annual preventive General health panel (including comprehensive metabolic panel, complete blood count, and thyroid stimulating hormone);
 - o. Annual preventive Urinalysis by dipstick or table reagent, non or automated with microscopy;
 - p. Lead Screening covered through the age of 21 years of age; and
 - q. Tuberculosis Screening covered through the age of 21 years of age.^{8]}

⁸ Applies to 17-279 only.

[BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Miscellaneous Health Interventions", Adult Immunizations is hereby amended to read as follows.

Adult Immunizations. Adult immunizations are generally not covered unless this Policy includes coverage for wellness. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for influenza immunizations for Covered Persons age 18 and older if administered by a Provider whose scope of practice includes administration of vaccines. Influenza immunizations are exempt from any copayment, Deductible or Coinsurance obligations but are limited to the Allowable Charge as determined by the Company. However, intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerasol per Covered Person per [Calendar Year][Benefit Period].⁹

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Dental Care or Orthodontic Services" is hereby amended to read as follows.

Dental Care or orthodontic services. Dental Care and orthodontic services are not covered. Hospital services related to any dental or orthodontic procedures, including children that require general anesthesia for dental caries or tooth decay care, are not covered.

However, if a Covered Person has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury with the following limitations:

- a. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
- b. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
- c. This benefit is limited to the first twelve (12) months immediately following the Accidental Injury. If the Covered Person is under age 15, reimbursement for Dental Care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of the Company, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Covered Person is in force when the treatment is rendered.
- d. Injury to teeth while eating is not considered an Accidental Injury.
- e. Double abutments are not covered.
- f. Any Health Intervention related to dental caries or tooth decay is not covered.
- g. Removal of impacted teeth is not covered.

Dental services in connection with radiation treatment for cancer of the head or neck are covered.

Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures are generally not covered. However, some services may be covered in accordance with Subsection 3.2.3.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Electrotherapy stimulators" is hereby amended to read as follows.

Electrotherapy stimulators. All treatment using electrotherapy stimulators, including services and supplies used in connection with such stimulators, and complications resulting from such treatment are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for a Transcutaneous Electrical

⁹ Applies to 17-236, 17-237, 17-238, 17-247, 17-258, 17-259, 17-260, 17-262 and 17-279

Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication. Coverage is also provided for neuromuscular electrical stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery until orthotic training begins.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Sleep Apnea, Portable Studies" is hereby amended to read as follows.

Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea are generally not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, coverage is provided for portable (at home) sleep studies when all of the following monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted In Situ Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Policy, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. See Subsection 3.10.3.

PROVIDER NETWORK AND COST SHARING PROCEDURES, "Network Procedures" are hereby amended to add the following new Subsection.

Scope of Provider Payment - Global Payment. The Company's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing

Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Preferred Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

GLOSSARY OF TERMS, "Allowable Charge" is hereby amended to read as follows.

Allowable Charge, when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Company, in its sole discretion, to be reasonable. The Arkansas Blue Cross and Blue Shield customary allowance is the basic Allowable Charge. However, Allowable Charge may vary, given the facts of the case and the opinion of the Company's medical director.

At the option of the Company, Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See Subsection 7.1.10 dealing with Out of Arkansas Claims. See Subsection 3.23.4 with respect to Allowable Charge for transplants. See Subsection 3.2.2 with respect to Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Policy are subject to and shall be paid only by reference to the Allowable Charge as determined at the discretion of Arkansas Blue Cross and Blue Shield. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Policy will be limited by the Allowable Charge we establish. If you use an Arkansas Blue Cross and Blue Shield-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of the Arkansas Blue Cross and Blue Shield Allowable Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, the Company's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Policy with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If the Company pays for a Covered Service by applying the Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to the Company, the Company shall have no further obligation, nor is there coverage under this Policy, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Policy are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and the Company will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills the Company for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, the Company will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Policy for any services, drugs, materials or supplies of the equipment and supply company. It is the Company's policy (and this Policy is specifically intended to adopt the same) that no benefits

shall be paid for "unbundled services" in excess of the Company's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Policy shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Policy will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is a Preferred Provider.

Please note that the Company makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, the Company will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Policy are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, the Company's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, the Company will not be responsible for paying multiple providers or multiple billings for the professional component, nor will the Company be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Policy will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

[GLOSSARY OF TERMS, "Primary Care Physician" is hereby amended to read as follows.

Primary Care Physician means a Preferred Provider Physician who provides primary medical care in one of these medical specialties: General Practice, Pediatrics, Family Practice, Obstetrics/Gynecology or Internal Medicine. This also includes advanced practice nurses or physician's assistants who provide primary medical care in these medical specialties and are performed in the Primary Care Physician's office.^{10]}

[POLICY PROVISIONS RELATIVE TO MEMBERSHIP, MEETING AND VOTING is hereby amended to add the following new provision.

Membership

By virtue of ownership of this Policy, the Policyholder is a member of Arkansas Blue Cross and Blue Shield. This Policy is a non-participating policy. This means that the Policyholder does not receive distribution of any premium, revenues, savings or assets of the Company.^{11]}

¹⁰ Applies to 17-279 only.

¹¹ Applies to all policies except 17-279

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

P. Mark White, President and Chief Executive Officer

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

State: Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: January 1, 2013 General Amendment - Individual

Project Name/Number: Amendment/23-2671 1/13

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/06/2012
Comments:	Please see attached.		
Attachment(s):	Flesch Certification Form 23-2671 1-13.pdf		
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/06/2012
Bypass Reason:	Not required.		
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	11/06/2012
Bypass Reason:	Not required.		
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	11/06/2012
Bypass Reason:	Not required.		
		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/06/2012
Bypass Reason:	Not PPACA related.		



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

**RE: Arkansas Blue Cross and Blue Shield
Amendment No. 23-2671 1/13**

**FLESCH READING EASE
CERTIFICATION**

This is to certify that the above referenced documents has achieved a Flesch Reading Ease Score average of 40.1 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.

Name

Vice President
Title

November 6, 2012
Date