

SERFF Tracking Number: ARBB-128230018 State: Arkansas  
Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number:  
Company Tracking Number: 23-2639; 2526; 2148  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO  
Product Name: General Amendment  
Project Name/Number: 7/1/2012 General Amendments/23-2639

## Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: General Amendment

SERFF Tr Num: ARBB-128230018 State: Arkansas

TOI: H16G Group Health - Major Medical

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

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

Co Tr Num: 23-2639; 2526; 2148

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Christi Kittler, Yvonne  
McNaughton, Frank Sewall, Rita

Disposition Date: 04/03/2012

Thatcher, Evelyn Laney

Date Submitted: 04/03/2012

Disposition Status: Approved-  
Closed

Implementation Date Requested: 07/01/2012

Implementation Date:

State Filing Description:

## General Information

Project Name: 7/1/2012 General Amendments

Status of Filing in Domicile: Pending

Project Number: 23-2639

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Arkansas is state  
of domicile.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 04/03/2012

State Status Changed: 04/03/2012

Deemer Date:

Created By: Christi Kittler

Submitted By: Christi Kittler

Corresponding Filing Tracking Number: 23-2639

PPACA: Not PPACA-Related

PPACA Notes: null

Healthcare.gov ID:

Filing Description:

Attached please find the general amendment form 23-2639 7/12 for your review and approval if indicated.

Amendment form 23-2639 amends specific benefit certificates to provide for an annual open enrollment period. We are

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deleting the 18-month preexisting condition limitation period for late enrollees to correlate with this change. This change does not apply to any Electronic Enrollment or BluesEnroll certificates. Additionally, we are deleting the reference to a filing fee under the "External Review" provision to correlate with Arkansas Insurance Department Rule and Regulation 76. It was inadvertently left in the last amendment cycle.

Amendment form 23-2526 has been modified to delete the Prior Approval requirement for all inpatient mental health benefits.

Amendment form 23-2148 has been amended to add "individual psychotherapy" to the list of services not covered with the specialty care physician copayment for clarification only. This does not represent a change in benefits.

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). Please also note, we have scored these amendments as part of the benefit certificates with which they will be used as provided by Arkansas Code Annotated §23-80-206(e).

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 is incorporated in the benefit certificates to which these amendments 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 these amendments is attached.

State Narrative:

## Company and Contact

### Filing Contact Information

Christi Kittler, Compliance Supervisor cmkittler@arkbluecross.com  
320 West Capitol, Ste 211 501-378-2967 [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: \$150.00  
Retaliatory? No  
Fee Explanation: \$50/form x 3 forms  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Arkansas Blue Cross and Blue Shield	\$150.00	04/03/2012	57674947

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/03/2012	04/03/2012

*SERFF Tracking Number:* ARBB-128230018      *State:* Arkansas  
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## **Disposition**

Disposition Date: 04/03/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	General Amendment	Approved-Closed	Yes
Form	Mental Health Parity Amendment	Approved-Closed	Yes
Form	PCP/SCP Benefit Amendment	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: 23-2639 7/12

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/03/2012	23-2639 7/12	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	General Amendment	Initial		43.700	23-2639 7-12.pdf
Approved-Closed 04/03/2012	23-2526 R7/12	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Mental Health Parity Amendment	Revised	Replaced Form #: 23-2526 R7/11 Previous Filing #: ARBB-127108110	43.700	23-2526 R7-12.pdf
Approved-Closed 04/03/2012	23-2148 R7/12	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	PCP/SCP Benefit Amendment	Revised	Replaced Form #: 23-2148 R9/08 Previous Filing #: N/A	43.700	23-2148 R7-12.pdf



**AMENDMENT TO THE  
ARKANSAS BLUE CROSS AND BLUE SHIELD  
COMPREHENSIVE MAJOR MEDICAL  
GROUP BENEFIT CERTIFICATES**

**AMENDMENT NO. 2639  
GENERAL AMENDMENT  
Form Nos. 163,164,232,233,234,235,239,240,241,242,  
243,244,245,246,263,265,266,267,268,269,270,271**

The following subsection amendments are effective on July 1, 2012.

**[SPECIFIC PLAN EXCLUSIONS, Preexisting and Other Conditions]**, Subsection 1, opening paragraph is hereby amended to read as follows.

Preexisting Conditions. No benefits or services of any kind are provided under this Benefit Certificate for treatment of a Preexisting Condition, for a period of twelve (12) months. This 12-month period is referred to as the "look forward period." If the Covered Person submits an application for coverage during the Waiting Period, the 12 month look forward period starts on the first day of the Waiting Period. If the Covered Person did not apply within the Waiting Period, the look forward period starts on the Covered Person's effective date.

**ELIGIBILITY FOR COVERAGE, Effective Date of Coverage**, Subsections 3-6 are hereby amended to read as follows. All remaining Subsection is hereby re-numbered to correlate with the change.

3. **Initial Enrollment of New Employees.** If the Company receives a new Employee's enrollment application within thirty (30) days of the date the Employee is first eligible for coverage, the Employee's coverage will become effective 12:01 a.m. on the first day of the Policy Month following the date the Employee is first eligible for coverage. However, if the date the Employee is first eligible for coverage falls on the first day of the Policy Month, the Employee's coverage will become effective at 12:01 a.m. on that day.
4. **Coverage in the Case of Late Enrollment.** If an Employee or an Employee's Dependent who is eligible for coverage does not make application for coverage in the Plan when initially eligible for coverage, the Employee or Dependent cannot subsequently obtain coverage, except during a Special Enrollment Period or an Open Enrollment Period.
5. **Open Enrollment Period.** Annually, during the period designated by the Employer and set forth in the Group Policy Application, Employees who are eligible for coverage may enroll in the Plan. During the Open Enrollment Period, Employees covered in the Plan may change their coverage, and that of their covered dependents. Unless otherwise designated in this Benefit Certificate, enrollments and coverage changes made during the Open Enrollment Period become effective on the anniversary date of the Group Policy.
6. **Effective Date for Existing Dependents.** If the Employee has eligible Dependents on the date the Employee's coverage begins, the Employee's Dependents' coverage will begin on the Employee's effective date if:
  - a. The Employee submits a written application for Dependents' coverage within 30 days of the Employee's effective date; and
  - b. The appropriate premium is timely paid.
7. **Initial Effective Date for Newly Acquired Dependents.** If an Employee acquires a new eligible Dependent after the date the Employee's coverage begins, coverage for a new Dependent will become effective in accordance with the following provisions:
  - a. **Spouse.** When an Employee marries and wishes to have the Employee's Spouse covered, the Employee shall submit an application or change form within 30 days of the date of marriage. The effective date will be the first of the Policy Month following the date of marriage. If an Employee submits the application or change form after the 30-day period, coverage for the Spouse will

become effective in accordance with the provisions for Late Enrollment. See Subsection 6.2.4, above.

- b. **Newborn Children.** Coverage for an Employee's newborn Child shall become effective as of the Child's date of birth if the Employee gives the Company notice by submitting an application or change form to the Company for the Child within 90 days of the Child's date of birth and the appropriate premium to cover the newborn Child from the date of birth is paid. If the Employee submits the application or change form after the applicable 90-day time period, coverage for the Employee's newborn Child will become effective in accordance with the provisions for Late Enrollment. See Subsection 6.2.4, above.
  - c. **Qualified Medical Child Support Order.** If a court has ordered an Employee to provide coverage for a Child, coverage will be effective on the first day of the month following the date the Company receives written notification and satisfactory proof of the court order. If the Employee fails to apply to obtain coverage for a Child, the Company shall enroll the Child on the first day of the month following the Company's receipt of a written application from a custodial parent of the Child, a child support agency having a duty to collect or enforce support for the Child, or the Child, provided, however that the premium is received when due. In the event a court has ordered an Employee of the Employer who is not covered by the Plan to provide coverage for a child, the Employee will be enrolled with the child on the first day of the month following the Company's receipt of a written application from the Employer, a custodial parent of the Child, a child support agency having a duty to collect or enforce support for the Child, or the Child, provided, however that the premium is received when due.
  - d. **Newly Adopted Children.** Subject to payment of all applicable premiums, coverage for a Child placed with an Employee for adoption or for whom the Employee has filed a petition for adoption, shall begin on the date the Child is placed for adoption or the date of the filing of the petition for adoption, provided an application for the Child's coverage is submitted to the Company within 60 days after the placement or the filing of the petition. The coverage shall begin from the moment of birth if the petition for adoption or placement for adoption occurred and the application for coverage is submitted to the Company within 60 days of the Child's birth. If the Employee submits the application or change form after such 60-day period, coverage for the adopted Child will become effective in accordance with the provisions for Late Enrollment. See Subsection 6.2.4, above. The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.
  - e. **Other Dependents.** Written application for enrollment received by the Company within 30 days of the date that any other dependent first qualifies as an eligible Dependent will result in coverage for such dependent on the first day of the Policy Month following the date that application for coverage is received by the Company. Such Dependent will not be a Late Enrollee. If the Employee submits the application or change form after the 30 day period, coverage for the Dependent will become effective in accordance with the provisions for Late Enrollment. See Subsection 6.2.4, above.
8. **Employee's Effective Date Controls.** In no event will a Dependent's coverage become effective prior to the Employee's Effective Date.
9. **Special Enrollment Period** is the 30-day period during which time an Employee or Dependent may enroll in the Plan, after his or her initial Eligibility Date or Open Enrollment Period and not be a Late Enrollee. Special Enrollment Periods occur **ONLY** in two instances:
- a. **After the Termination of Another Health Plan.** A Special Enrollment Period occurs (i) after an employee's or dependent's coverage under another health plan terminated as a result of Loss of Eligibility, or (ii) after the employer providing such other health plan coverage terminated its contributions. The

coverage effective date will be the 1<sup>st</sup> day of the Policy Month following loss of prior coverage.

- b. **After the Addition of a Dependent.** A Special Enrollment Period occurs for an Employee, Spouse or Employee's new dependent Child (i) after the Employee marries, (ii) after an Employee's Child is born, or (iii) after an Employee adopts a Child or has a Child placed with the Employee for adoption. The effective date of coverage shall be governed by the provisions of this Benefit Certificate concerning addition of a Spouse, a newborn Child or an adopted Child, as applicable.<sup>1]</sup>

**CLAIM PROCESSING AND APPEALS, Independent Medical Review of Claims (External Review), "Filing Fee"** is hereby deleted in its entirety. All remaining Subsections are hereby renumbered to correlate with the change.

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

**Open Enrollment Period** means the period annually, that is designated by the Employer and set forth in the Group Application, when Employees who are eligible for coverage may enroll in the Plan. During the Open Enrollment Period, Employees covered in the Plan may change their coverage, and that of their covered Dependents. Unless otherwise designated in this Benefit Certificate, enrollments and coverage changes made during the Open Enrollment Period become effective on the anniversary date of the Group Policy. If for any reason, Employer fails to designate an Open Enrollment Period, or the Group Application fails to indicate it, the Open Enrollment Period shall be the month prior to the anniversary of the effective date of the Group Policy.

**GLOSSARY OF TERMS, Special Enrollment Period** is hereby amended to read as follows.

**Special Enrollment Period** means a thirty (30) day period during which time an Employee or Employee's Dependent may enroll in the Plan, after his or her initial Waiting Period or the Open Enrollment Period and not be a Late Enrollee. Special Enrollment Periods occur in two instances:

1. **AFTER THE TERMINATION OF ANOTHER HEALTH PLAN:** A Special Enrollment Period occurs (i) after an Employee's or Dependent's coverage under another health plan terminated as a result of Loss of Eligibility or (ii) after the employer providing such other health Plan terminated its contributions.
2. **AFTER THE ADDITION OF A DEPENDENT:** A Special Enrollment Period occurs for an Employee, Employee's Spouse or Employee's new Dependent Child (i) after the Employee marries; (ii) after a Employee's Child is born or (iii) an Employee adopts a Child or has a Child placed with the Employee for adoption.

**YOUR RIGHTS UNDER ERISA, Creditable Coverage** is hereby amended to read as follows.

**Creditable Coverage**

The Plan provides a reduction or elimination of exclusionary periods of coverage for Preexisting Conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to Preexisting Condition exclusion for 12 months after your enrollment in your coverage.<sup>2]</sup>

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<sup>1</sup> Applies to 17-232, 17-233, 17-234, 17-235, 17-239, 17-240, 17-268 only

<sup>2</sup> Applies to 17-232, 17-233, 17-234, 17-235, 17-239, 17-240, 17-268 only

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Group Benefit Certificate. All other provisions 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



Arkansas  
**BlueCross BlueShield**  
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**AMENDMENT TO THE  
ARKANSAS BLUE CROSS AND BLUE SHIELD  
COMPREHENSIVE MAJOR MEDICAL  
GROUP BENEFIT CERTIFICATES**

**AMENDMENT NO. 2526  
MENTAL HEALTH PARITY  
FORM NOS. 163, 164, 232, 233, 234, 235, 239, 240, 241, 242, 243, 244, 245, 246,  
263, 265, 266, 267, 268, 269, 270, 271**

**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 Benefit Certificate, 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 the following requirements.
    - 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 outpatient setting.
    - 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 outpatient setting.
  - b. Coverage is subject [to the Inpatient Hospital Copayment and] 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 Benefit Certificate exists.**

4. The following services and treatments are not covered.
  - a. **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 Specific Plan Exclusions, "Health Interventions."
  - b. **Hypnotherapy.** Hypnotherapy is not covered for any diagnosis or medical condition. See Specific Plan Exclusions, "Health Interventions."
  - c. **Marriage and Family Therapy.** Marriage and family therapy or counseling services are not covered. See Specific Plan Exclusions, "Health Interventions."
  - d. **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 Specific Plan Exclusions, "Health Interventions."

**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 Group Benefit Certificates. All other provisions of the Group Benefit Certificate remain in full force and effect.

*P. Mark White*

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P. Mark White, President and Chief Executive Officer

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**AMENDMENT TO THE  
ARKANSAS BLUE CROSS AND BLUE SHIELD  
COMPREHENSIVE MAJOR MEDICAL  
GROUP BENEFIT CERTIFICATES**

**AMENDMENT NO. 2148  
PRIMARY CARE PHYSICIAN &  
SPECIALTY CARE PHYSICIAN  
OPTIONAL BENEFITS**

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

**Primary Care Physician Benefits**

**Specialty Care Physician Benefits**

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

**Primary Care Physician Benefits.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for services 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 practice or internal medicine, which are performed in the Primary Care Physician's office. The Coinsurance amount the Company will pay for the services listed below is one hundred percent (100%) of the Allowable Charge or the amount of the billed charge for the service whichever is less, subject to the Primary Care Physician copayment amount listed in the Schedule of Benefits. Services subject to the copayment include but are not limited to:

1. Office Visit;
2. Diagnostic X-rays;
3. Lab;
4. Surgery by the Primary Care Physician;
5. Accident or Emergency Medical Care;
6. Allergy Shots; and
7. Injections.

**PLEASE NOTE: Services performed by a Non-Preferred Provider are subject to the Deductible and Out-of-Network Coinsurance, not the Primary Care Physician copayment. Services performed for Psychiatric Conditions and substance abuse, including alcoholism, are subject to the Deductible and Appropriate Coinsurance, not the Primary Care Physician copayment. Services subject to a copayment do not apply toward meeting your Deductible or Calendar Year Coinsurance Maximum, regardless of the type of Physician providing care.**

**Specialty Care Physician Benefits.**

1. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for services provided by a Specialty Care Physician or an advanced practice nurse or physician's assistant who provides medical care in the area of the Specialty Care Physician's practice, which are performed in the Specialty Care Physician's office. The Coinsurance amount the Company will pay for the services listed below is one hundred percent (100%) of the Allowable Charge or the amount of the billed charge for the service whichever is less, subject to the Specialty Care Physician copayment amount listed in the Schedule of Benefits. Services subject to the copayment include but are not limited to:

- a. Exam/evaluation/consult;
  - b. Lab;
  - c. Plain Film Radiographs;
  - d. Many commonly administered injections (See Subsection 3.f. below);
  - e. Allergy testing; and
  - f. Audiology testing;
2. In order to be covered:
- a. The services must be rendered by the same Specialty Care Physician who provided face-to-face examination, evaluation or consult on the day of the services, and
  - b. The services must be billed on the same claim as the examination, evaluation or consult.
3. Certain other services provided by a Specialty Care Physician, even if such services meet the requirements of Subsection 2. above of this benefit, are not covered under the copayment, but are covered subject to the Deductible, Coinsurance and dollar or visit limits as listed in the Schedule of Benefits. Among these services are:
- a. Surgery;
  - b. Chemotherapy / Radiation therapy;
  - c. Hemodialysis;
  - d. individual psychotherapy;
  - e. Physical therapy;
  - f. Speech therapy; and
  - g. Injections not included under the Specialty Care Physician copayment include medications used primarily in the treatment of cancer, chemotherapy side-effects, infertility, impotence, pregnancy problems, coagulation factor diseases, HIV, adenosine deaminase deficiency, and Gaucher's and other related diseases. Other types of injections not included under the Specialty Care Physician copayment are hormones, anti-fungals, anabolic steroids, anti-virals, abortifacients, immunosuppressive drugs for transplants, bone resorption inhibitors, Botox, pulmonary artery anti-hypertensives, thrombolytic agents, cultured chondrocytes implants, Alpha 1 proteinase inhibitors, tissue grafts, anesthesia and those used to aid in other diagnostic tests, surgery, dialysis, or other injections. Medications for filling or refilling of infusion pumps are not included. Non-specific injection codes will also not be covered under the Specialty Care Physician copayment.
4. **PLEASE NOTE: Services performed by a Non-Preferred Provider are subject to the Deductible and Out-of-Network Coinsurance, not the Primary Care Physician or the Specialty Care Physician copayment. Services performed for Psychiatric Conditions and substance abuse, including alcoholism, are subject to the Deductible and Coinsurance, not the Primary Care Physician or the Specialty Care Physician copayment. Services subject to a copayment do not apply toward meeting your Deductible or Calendar Year Coinsurance Maximum, regardless of the type of Physician providing care.**

**PROVIDER NETWORK AND COST SHARING PROCEDURES**, Subsection 5.2.1 is hereby amended to add the following new provision.

No Deductible is applicable to those services and supplies, which are subject to the Primary Care Physician copayment or the Specialty Care Physician copayment amount listed in the Schedule of Benefits.

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

**Plain Film Radiograph** means a routine film x-ray performed in a Specialty Care Physician's office and provided in accordance with Coverage Policy established by the Company.

**Primary Care Physician** means a Preferred Provider Physician who provides primary medical care in one of these medical specialties: General Practice, Pediatrics, Family Practice or Internal Medicine

**Specialty Care Physician** means a Preferred Provider Physician with any specialty other than primary care who practices such specialty and who has met the participation standards of the Company. (Specialty Care Physicians do not include the following: Family Practice, General Practice, Internal Medicine, Pediatrics)

This Amendment becomes a part of the Arkansas Blue Cross and Blue Shield Managed Benefits Comprehensive Major Medical Group Benefit Certificates. All other provisions of the Group Benefit Certificate 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

<i>SERFF Tracking Number:</i>	<i>ARBB-128230018</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Arkansas Blue Cross and Blue Shield</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>	<i>23-2639; 2526; 2148</i>		
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001A Any Size Group - PPO</i>
<i>Product Name:</i>	<i>General Amendment</i>		
<i>Project Name/Number:</i>	<i>7/1/2012 General Amendments/23-2639</i>		

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> See attached. <b>Attachment:</b> Flesch Certification 23-2639.pdf	Approved-Closed	04/03/2012

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> N/A <b>Comments:</b>	Approved-Closed	04/03/2012

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary <b>Bypass Reason:</b> Not PPACA related. <b>Comments:</b>	Approved-Closed	04/03/2012



# Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

RE: **Arkansas Blue Cross and Blue Shield**  
Form Nos. **23-2639 7/12, 23-2526 R7/12, 23-2147 R7/12**

## FLESCH READING EASE CERTIFICATION

This is to certify that the above referenced documents have achieved a Flesch Reading Ease Score average of 43.7 and comply with the requirements of A.C.A. §23-80-201 *et. seq.*, cited as the Life and Health Insurance Policy Language Simplification Act.

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Name

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Senior Vice President

Title

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April 2, 2012

Date