



**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
GROUP BENEFIT CERTIFICATES**

**AMENDMENT NO. 2479
GENERAL AMENDMENT
Form Nos. 163,164,232,233,234,235,239,240,241,242,243,244,245,246**

The following subsection amendments are effective on January 1, 2009.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Hospital Services, Subsection 1.b., is hereby deleted in its entirety. All remaining subsections are renumbered to correlate with the change.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Hospital Services, Subsection 2. Outpatient Hospital Services is hereby amended to read as follows.

Outpatient Hospital Services. Coverage is provided for services of a Outpatient Hospital, Outpatient Surgery Center or Outpatient Radiation Therapy Center. However, if you use an out of state Outpatient Surgery Center that does not contract with the local Blue Cross and Blue Shield Plan, payment for all such services, including professional fees, will be limited to the charges for all the services or \$500 whichever is less.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Ambulatory Surgery Center is hereby amended to read as follows.

Ambulatory Surgery Center. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate and subject to the Deductible and Coinsurance specified in the Schedule of Benefits, coverage is provided for specific surgical services received at an Ambulatory Surgery Center that are performed or prescribed by a Physician. Covered services include diagnostic imaging and laboratory services required to augment a surgical service and performed on the same day as such surgical service. Ambulatory Surgery Center services in connection with treatment for a complex dental condition are provided in accordance with Subsection 3.2.3. However, if you use an out of state Ambulatory Surgery Center that does not contract with the local Blue Cross and Blue Shield Plan, payment for all such services, including professional fees, will be limited to the Allowable Charges incurred for all the services or \$500, whichever is less.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Durable Medical Equipment, Subsection 1, is hereby amended to read as follows.

Durable Medical Equipment is equipment which (1) can withstand repeated use; and (2) is primarily and customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an illness or injury; and (4) is appropriate for use in the home. Coverage for Durable Medical Equipment and Medical Supplies is provided when the Durable Medical Equipment is provided in accordance with Coverage Policy. Examples of Durable Medical Equipment include, but are not limited to, oxygen equipment, wheelchairs and crutches.

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

Coverage for Medical Supplies used in connection with Durable Medical Equipment is limited to a 90-day supply per purchase.

BENEFITS AND SPECIFIC LIMITATION IN YOUR PLAN, Medications, Subsection 2.b. is hereby amended to read as follows.

Specialty Medications. Selected Prescription Medications are designated by the Company as "Specialty Medications" due to their route of administration, approved indication, unique nature, or inordinate cost. These medications usually require defined handling and home storage demands, crucial patient education, and careful monitoring. Such medications include, but are not limited to growth hormones, blood modifiers, immunoglobulins, and medications for the treatment of hemophilia, deep vein thrombosis, hepatitis C, Crohn's disease, cystic fibrosis, multiple sclerosis and rheumatoid arthritis. Specialty Medications may be A Medications or B Medications. Coverage for Specialty Medications is subject to Prior Approval and may only be purchased through a specialty pharmacy vendor under contract with the Company. The benefit for a Specialty Medication that is designated by the Company as "Specialty Medication 1" is subject to the Prescription Drug Copayment specified in the Schedule of Benefits. The benefit for a Specialty Medication that is classified by the Company as "Specialty Medication 2" is subject to the Calendar Year Deductible and Coinsurance specified in the Schedule of Benefits. A list of Specialty Medications is available from the Company upon request or, if you have Internet access, you may review this list on the Company's web site at WWW.ARKANSASBLUECROSS.COM. This Subsection 3.22.2.b is applicable to Prescription Medication covered by Subsections 3.22.1.b, c. and d.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Organ Transplant Services, Subsection 5. is amended to read as follows.

Notwithstanding any other provisions of this Benefit Certificate, at the option of the Company, the Allowable Charge for an organ transplant, including any charge for the procurement of the organ, hospital services, physician services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) ninety percent (90%) of the billed charges or (b) the global payment determined as payment in full by a Blue Cross and Blue Shield Association Blue Distinction Centers for Transplant participating facility, if the Covered Person chooses to use that facility. If the Covered Person receives the transplant from a facility outside of Arkansas that is not in the Blue Distinction Centers for Transplant network, but is contracted with a local Blue Cross and/or Blue Shield Plan, the Allowable Charge shall be the price contracted by such Blue Cross and/or Blue Shield Plan. (See Section 7.1.10 Out of Arkansas Claims). If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network and does not contract with the local Blue Cross and/or Blue Shield plan, the Allowable Charge for the transplant services provided in the Transplant Global Period is eighty (80%) percent of an amount equaling the lesser of (a) ninety (90%) percent of billed charges or (b) the average allowable charge authorized by participating facilities in the Blue Distinction Centers for Transplant network located in the geographic region where the transplant is performed. **Please note that our payments for any transplant (whether performed within the transplant network or by a non-participating facility) are limited to a global payment that applies to all covered transplant services; we will not pay any amounts in excess of the global payment for services the facility or any physician or other health care Provider or supplier may bill or attempt to bill separately, because the global payment is deemed to include payment for all related necessary services (other than non-covered services). If you use a facility participating in the Blue Distinction Centers for Transplant network, that facility has agreed to accept the global payment as payment in full, and should not bill you for any excess amount above the global payment, except for applicable Deductible, Coinsurance or non-covered services; however, a non-participating facility may bill you for all amounts it may charge above the global payment. These charges above the global payment could amount to thousands of dollars in additional out of pocket expenses to you.**

[SPECIFIC PLAN EXCLUSIONS, Health Interventions, “Maternity Care and Obstetrical Care” exclusion is hereby amended to read as follows.

Maternity Care and Obstetrical Care. Services or supplies for Maternity Care and Obstetrical Care, in-vitro fertilization, artificial insemination or any other treatment, diagnostic test, or care related to any of the above, are not covered. ^{1]}

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, Chief Executive Officer

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

¹ This provision applies to all group certificates listed in this amendment but will only print for groups that do not cover maternity benefits.