November 2, 2011

At Arkansas Blue Cross and Blue Shield, our goal always is to make the complex issues around health coverage as simple as possible. Therefore, we are modifying some of the language in your Arkansas Blue Cross Group Benefit Certificates. Enclosed please find an amendment – effective January 1, 2012 – outlining the following changes:

**Newborn Care in the Hospital**
We have amended the "Newborn Care in the Hospital" benefit for all groups with maternity benefits to clarify that coverage for a newborn is contingent on the employee adding the newborn to the policy in accordance with Section 6.0. This is a clarification only and does not represent a benefit change.

**Federally Funded Programs**
We have added an exclusion for any provider (hospital or other facility, doctor or other individual practitioner) who has been excluded from participation in any federally funded programs. This means that no benefits will be provided under your Arkansas Blue Cross and Blue Shield Group Benefit Certificates for any services of such excluded providers, including, where applicable, for prescriptions ordered or written by an excluded physician or presented to or filled by an excluded Pharmacy.

**Gastric Pacemakers**
Act 1042 of Arkansas' 88th General Assembly requires coverage for gastric pacemakers for individuals with gastroparesis. We have added a benefit for gastric pacemakers and also deleted the exclusion for gastric stimulators to comply with the new law.

**Pilot Projects Provision**
We have also added a new benefit for pilot projects which may provide additional coverage depending on the pilot project we are conducting at the time.

**External Review**
We have amended the Claim Processing and Appeals section to comply with the new federal requirements under Patient Protection and Affordable Care Act (PPACA) dealing with External Review as well as the Arkansas Insurance Departments new External Review rule.
Please attach this amendment to your Group Benefit Certificate. If you have any questions, please don't hesitate to contact Customer Service at 1–800–238–8379 or your regional office group service representative.

Thank you for your business. It is our privilege to provide your health insurance!

P. Mark White
P. Mark White
President
The following subsection amendments are effective on January 1, 2012.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Therapy Services, "Group Therapy" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Maternity," Subsection 3. is hereby amended to read as follows.

Newborn Care in the Hospital. Provided the child's coverage becomes effective on his or her date of birth in accordance with the provisions of Section 6.0, coverage is provided for a hospital stay for the mother and newborn child of at least forty-eight (48) hours following a vaginal delivery or at least ninety-six (96) hours following a cesarean section, unless the treating provider, after consulting with the mother, discharges the mother or newborn child earlier. An Employee 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.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Medications, Subsection c. is hereby amended to add the following new Subsection. All remaining Subsections are hereby re-numbered to correlate with the change.

Prescriptions, Excluded Providers. Prescriptions ordered or written by any Physician or Provider who is excluded from coverage under the Plan, are not covered. Prescriptions presented to or filled by any Pharmacy which is excluded from coverage under the Plan, are not covered. See Subsection 4.2.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Miscellaneous Health Interventions" is hereby amended to add the following new Subsections.

Gastric Pacemaker Coverage. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate including the Deductible and Coinsurance set out in the Schedule of Benefits, coverage is provided for gastric pacemakers that receive Prior Approval from the Company. Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the gastric pacemaker meets the Primary Coverage Criteria requirements set out in Subsection 2.2. and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. All services, including any gastric pacemaker receiving Prior Approval, must still meet all other coverage terms, conditions, and limitations, and coverage for any gastric pacemaker receiving Prior Approval may still be limited or denied if, when the claims for the gastric pacemaker 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 any other basis specified in this Benefit Certificate.

Pilot Project Coverage. Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, from time to time, the Company may provide coverage of medical interventions that are excluded under the terms of the Plan as set out in this Benefit Certificate, under terms, conditions, exclusions and limitations of a Company authorized Pilot Program. You can learn the medical interventions that are covered by a Company authorized Pilot Program, and the terms, conditions, exclusions and limitations of such coverage by visiting the Company's website at WWW.ARKANSASBLUECROSS.COM or by calling Customer Service.
SPECIFIC PLAN EXCLUSIONS, Health Care Providers is hereby amended to add the following new Subsection. All remaining Subsections are re-numbered to correlate with the change.

Provider, Excluded. Health Interventions received from any Provider who has been excluded from participation in any federally funded program, are not covered.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Gastric Electrical Stimulators" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Group Therapy" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

CLAIM PROCESSING AND APPEALS, Claim Processing, "Explanation of Benefit Determination" Subsection a. is hereby amended to read as follows.

The specific reason or reasons for the determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Covered Person may learn the diagnosis and treatment codes and their descriptions);

CLAIM PROCESSING AND APPEALS, Claim Appeals to the Plan (Internal Review), "Documentation" Subsection b. is hereby amended to read as follows.

Appellant’s Right to Information. The Company shall provide you free of charge and sufficiently in advance of the date of the final internal adverse benefit determination to give you a reasonable opportunity to respond, reasonable access to, and copies of, all documents, records or other information that:

i. were relied upon in making the benefit determination;

ii. were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;

iii. demonstrate compliance with the terms of the Plan; or

iv. constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

CLAIM PROCESSING AND APPEALS, Claim Appeals to the Plan (Internal Review), "Notification of Determination of Appeal to Plan" Subsection a. is hereby amended to read as follows.

The specific reason or reasons for the review determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Covered Person may learn the diagnosis and treatment codes and their descriptions);

CLAIM PROCESSING AND APPEALS, Independent Medical Review of Claims (External Review) "Claim Appeals Subject to External Review", is hereby amended to read as follows.

1. Claim Appeals Subject to External Review.

   a. Waiver of Internal Review. If we have waived internal review, your appeal shall be to external review in accordance with this Section 7.3.

   b. Application of Primary Coverage. If your claim has not been the subject of a prior external review and if we have denied your claim in whole or in part because the intervention did not meet the Primary Coverage Criteria (other than under the conditions outlined in Subsections 2.4.1.a., b., c. or d.) or because of the application of a Coverage Policy, you may request an independent medical review by an Independent Review Organization in accordance with the provisions of this Subsection 7.3 provided:

      i. The claim denial was upheld in whole or in part as a result of the Plan’s internal review process, or

      ii. You have not requested or agreed to a delay in the Plan’s internal review process and the Appeals Coordinator has not given you notification of the
determination involving a pre-service claim appeal within thirty (30) days following receipt of your appeal to the Plan; or

iii. You have not requested or agreed to a delay in the Plan’s internal review process and the Appeals Coordinator has not given you notification of the determination involving a post-service claim appeal within sixty (60) days following receipt of your appeal to the Plan; or

iv. Your claim meets the requirements for expedited external review, (see Subsection 7.3.13) and you have simultaneously submitted an appeal to the Plan.

2. Where and When to Submit External Review Appeal. You may request external review by submitting a request for external review to the Arkansas Insurance Commissioner, 1200 West Third Street, Little Rock, Arkansas 72201 or by calling 1-800-282-9134. Your request must be made within four (4) months after you were notified that the claim denial was upheld in whole or in part as a result of the Plan’s internal review process. If Subsection 7.3.1.b.ii. or 7.3.1.b.iii. apply, your request may be made at the end of the thirty (30) day period or sixty (60) day period. If Subsection 7.3.1.b.iv. applies, you must file your request for external review at the same time you file your appeal to the Plan.

3. Independent Review Organization and Independent Medical Reviewer
   a. The Arkansas Insurance Commissioner shall determine if the claim is subject to external review, and if he so determines, assign an Independent Review Organization from the list of approved Independent Review Organizations compiled and maintained by the Commissioner.
   b. The Independent Review Organization is not affiliated with, owned by or controlled by the Company. The Company pays a reasonable fee to the Independent Review Organization to conduct the review, but such fee is not contingent upon the determination of the Independent Review Organization or Independent Medical Reviewer.
   c. An Independent Medical Reviewer is a physician that is licensed in one or more States to deliver health care services and typically treats the condition or illness that is the subject of the claim under review. The Independent Medical Reviewer is not an employee of the Company and does not provide services exclusively for the Company or for individuals holding insurance coverage with the Company. The Independent Medical Reviewer has no material financial, familial or professional relationship with the Company, with the Plan Administrator, with an officer or director of the Company or the Plan Administrator, with the claimant or the claimant’s Authorized Representative, with the health care professional that provided the intervention involved in the denied claim; with the institution at which the intervention involved in the denied claim was provided; with the manufacturer of any drug or other device used in connection with the intervention involved in the denied claim; or with any other party having a substantial interest in the denied claim.

4. Documentation
   a. Written Appeals. You must submit your appeal in writing in a form and in a manner determined by the Arkansas Insurance Commissioner. You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.
   b. Authorization to Release Information. In filing your request for external review, you must include the following authorization: “I, [Covered Person’s name], authorize Arkansas Blue Cross and Blue Shield and my healthcare Provider(s) to release all medical information or records pertinent to this claim to the Independent Review Organization that is designated by Arkansas Blue Cross. I further authorize such Independent Review Organization to release such medical information to any Independent Medical Reviewer(s) selected by the Independent Review Organization to conduct the review.”

5. Referral of Review Request to an Independent Review Organization. Upon receipt of the documentation set out in Subsection 7.3.4, the Arkansas Insurance Commissioner shall immediately refer the request for external review, along with the Company’s initial determination
of the claim and the Appeals Coordinator’s internal review determination (if applicable) to an Independent Review Organization.

6. **Independent Review Organization Right to Information.** You and your treating health care professional are required to provide the Independent Review Organization and the Independent Medical Reviewer(s), upon request, access to information necessary to determine the appeal. Access to such information shall be provided not later than seven (7) business days after the date on which the request for information is received.

7. **Rejection of Request for Review by the Independent Review Organization.** The Independent Review Organization shall reject a request for review and notify you, your Authorized Representative and the Appeals Coordinator in writing within five (5) business days (or within 72 hours for an Expedited Appeal) of its determination, if it determines that the appeal does not meet the standards for an appeal for external review. See Subsections 7.3.1.

8. **Rejection of the Review for Failure to Submit Requested Information.** The Independent Review Organization may reject a request for review if:
   a. you have not provided the authorization for release of medical records or information pertinent to the claim required by Subsection 7.3.4.b; or
   b. you or your health care professional have not provided information requested by the Independent Review Organization in accordance with Subsection 7.3.6.

9. **Independent Medical Review Determination.** If the Independent Review Organization does not reject the request for review in accordance with Subsections 7.3.7 or 7.3.8, it shall assign the request for review to an Independent Medical Reviewer. Such Independent Medical Reviewer shall make a determination after reviewing the documentation submitted by you, your health care professional and the Company. The Independent Medical Reviewer shall consider the terms of this Benefit Certificate to assure that the reviewer’s decision is not contrary to the terms of the Plan. In making the determination the reviewer need not give deference to the determinations made by the Company or the recommendations of the treating health care professional (if any).

10. **Timing of Appeal Determination.**
    a. **Standard Review.** The Independent Medical Reviewer shall complete a review on an appeal within a reasonable period of time, but in no case later than forty five (45) days after the Independent Review Organization received the appeal.
    b. **Expedited Review.** If you request an expedited review, and a health care professional certifies that the time for a standard review would seriously jeopardize your life or health or your ability to regain maximum function, the Independent Medical Reviewer shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Independent Review Organization received the request for review.

11. **Notification of Determination of Independent Medical Review.**
    a. **Recipients of Notice.** Upon receipt of the determination of the Independent Medical Reviewer, the Independent Review Organization shall provide written notification of the determination to you, your health care Provider, the Company and the Arkansas Insurance Commissioner.
    b. **The Notification shall include.**
       i. A general description of the reason for the request for external review;
       ii. The date the Independent Review Organization was notified by the Company to conduct the review;
       iii. The date the external review was conducted;
       iv. The date of the Independent Medical Reviewer’s determination;
       v. The principal reason(s) for the determination;
       vi. The rationale for the determination; and
       vii. References to the evidence or documentation, including practice guidelines, considered in the determination.

12. **Expedited External Review.**
    a. **Requirement for Expedited Review.** You may submit a pre-service claim denial or a denial of a claim involving concurrent care for an expedited external review provided
your health care professional certifies that the time to complete a standard review would seriously jeopardize your life or health or your ability to regain maximum function.

b. **Expedited External Review without prior Appeal to Plan (internal review).** You may request an expedited review at the same time you submit a request for an appeal to the Plan (internal review) if your health care professional certifies that the time to complete the Plan's expedited appeal process would seriously jeopardize your life or health or your ability to regain maximum function. If you make such a request, the Independent Review Organization may determine and notify you in accordance with Subsections 7.3.10.b and 7.3.11 whether you will be required to complete the internal review process.

c. **Same procedures as standard external review.** Unless otherwise specified, the provisions of this Section 7.3 applicable to independent medical review of claims apply to expedited external review of claims.

13. **Other Rights under Plan.** Your decision to submit an appeal to external review will have no effect on your other rights and benefits under the Plan.

14. **Arkansas Insurance Commissioner.** You may contact the Arkansas Insurance Commissioner for assistance. The mailing address is Arkansas Insurance Department, Attention External Review Assistance, 1200 West Third Street, Little Rock, Arkansas 72201. The telephone number is 501-371-2540 or toll free 800-282-9134. The e-mail address is INSURANCE_CONSUMERS@ARKANSAS.GOV.

15. **Filing Fee.** You are required to pay a twenty-five dollar ($25) fee to submit an appeal for external review. If the external review results in a reversal of the claim denial, in whole or in part, the Company will refund your filing fee. This twenty-five dollar ($25) filing fee will be waived if (1) you have previously paid seventy-five dollars ($75) in filing fees during the plan year or (2) paying of the fee will impose an undue financial hardship.

16. **Binding on the Plan.** The determination of an Independent Review Organization and an Independent Medical Reviewer is binding on both the Plan and you, except to the extent that other remedies are available under applicable federal or state law.

**GLOSSARY OF TERMS, Health Interventions** is hereby amended to read as follows.

Health Intervention or Intervention means an item, Medication or service delivered or undertaken primarily to diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body.

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.

\[\text{Signature}\]

P. Mark White, President and Chief Executive Officer

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

23-2612 1/12
Arkansas Blue Cross and Blue Shield
Grandfathered Health Plan
Notice

Arkansas Blue Cross and Blue Shield believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Arkansas Blue Cross and Blue Shield at 1–800–238–8379. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.