The following subsection amendments are effective on January 1, 2007.

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

**Durable Medical Equipment.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for Durable Medical Equipment (DME) when prescribed by a Physician according to the guidelines specified below. This benefit, together with the benefit for equipment under Subsection 3.14, Diabetes Management Services, and Subsection 3.17, Home Health Services, is subject to the Deductible and Coinurance specified in the Schedule of Benefits, and has a benefit limitation of $5,000.00 per calendar year.

1. 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 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, contraceptive devices and crutches.

2. Durable Medical Equipment delivery or set up charges are included in the Allowable Charge for the Durable Medical Equipment.

3. A single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery is covered. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. The Allowable Charge is based on the cost for basic glasses or contact lenses. You can determine the amount of this Allowable Charge by contacting Customer Service.

4. Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Covered Person.

5. When it is more cost effective, the Company in its discretion will purchase rather than lease equipment. In making such purchase, the Company may deduct previous rental payments from its purchase Allowance.

**BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN**, Organ Transplant Services, Subsections 12 and 13 are hereby moved to Miscellaneous Health Interventions.

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

Subject to the Covered Person’s payment of the Deductible and the appropriate Coinurance 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, Coinurance, Deductible or dollar limit provisions. Intranasally administered influenza vaccination(s) such as Flumist are subject to the maximum benefit the Plan allows for injectable influenza vaccine without thimerosal per Covered Person per Calendar Year.

**BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN**, Miscellaneous Health Interventions is hereby amended to read as follows.

23-2350 1/07
Miscellaneous Health Interventions. Subject to all other terms, conditions, exclusions and limitations of the Plan set forth in this Benefit Certificate, coverage is provided for the following:

1. **Adult Immunizations.** Adult immunizations are generally not covered unless this Benefit Certificate includes coverage for wellness. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, 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.

2. **Chelation Therapy.** Chelation therapy is generally not covered, see Subsection 4.3.13. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson’s disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered.

3. **Colorectal Cancer Examinations and Laboratory Tests.** Screening tests are generally not covered, see Subsection 4.3.77; however, subject to all other 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 colorectal cancer screening and Laboratory tests when performed or prescribed by a Physician and provided in accordance with the guidelines established by the State Health Department.

4. **Electrotherapy stimulators.** Treatment using electrotherapy stimulators are generally not covered, see Subsection 4.3.26. However, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication.

5. **Enteral Feedings.** Enteral feedings are generally not covered, see Subsection 4.3.28. However, enteral feedings are covered when such feedings have been approved and documented by a Physician as being the Covered Person’s sole source of nutrition.

6. **Inotrope Agents for Congestive Heart Failure.** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. See Subsection 4.3.49. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, where the patient is on a cardiac transplant list at a hospital where there is an ongoing cardiac transplantation program, the Plan will cover infusion of inotropic agents.

7. **Trans-telephonic Home Spirometry.** Trans-telephonic home or ambulatory spirometry is not covered. See Subsection 4.3.93. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, trans-telephonic home spirometry is covered for patients who have had a lung transplant.

8. **Vision enhancement.** Vision enhancements are generally not covered, see Subsection 4.3.96. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye are 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 multifocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. The Plan does not cover the implantation of a multifocal lens; however, if a multifocal lens is implanted after cataract extraction, the Plan will pay the Allowable Charge for a multifocal lens. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. See Subsection 3.11.3.

**SPECIFIC PLAN EXCLUSIONS,** 4.3 Health Interventions, Genetic Tests is hereby amended to read as follows.

In general, genetic testing to determine: (1) the likelihood of developing a disease or condition, (2) the presence of a disease in a relative, (3) the likelihood of passing an ineritable disease or congenital abnormality to an offspring, or (4) genetic testing of the products of amniocentesis to determine the presence of a disease or congenital anomaly in the fetus, or (5) genetic testing of a symptomatic Covered Person’s blood or tissue to determine if the Covered Person has a specific disease are not covered. However, subject to the terms, conditions, exclusions, and limitations of the Plan set forth in this Benefit Certificate, a limited number of specific genetic tests may be covered for situation (4) or (5) (referenced above) when the Company has determined that the genetic test is the only way to diagnose the disease and the result will affect treatment.
SPECIFIC PLAN EXCLUSIONS, 4.3 Health Interventions, Screening Tests are hereby amended to read as follows.

Screening Tests. Services for Screening Tests are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, the Plan will cover Children preventive health care service as outlined in subsection 3.24, one eye examination to screen for diabetic retinopathy per calendar year for Covered Persons who are diagnosed with diabetes and colorectal cancer screening when performed or prescribed by a Physician and provided in accordance with the guidelines established by the State Health Department.

SPECIFIC PLAN EXCLUSIONS, 4.3 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. Keratoprosthesis is not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, 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 3.11.3.

PROVIDER NETWORK AND COST SHARING PROCEDURES, Subsection 5.1.4 is hereby amended to read as follows.

No Balance Billing from Preferred Providers and Contracting Providers. Preferred Providers and Contracting Providers are Physicians or Hospitals who are paid directly by the Company and have agreed to accept the Company's payment for covered services as payment in full except for your Deductible, Coinsurance and any specific benefit limitation, e.g. Ambulance Service $1000 per year (Subsection 3.15), if applicable. A Covered Person is responsible for billed charges in excess of the Company's payment when Physicians or Hospitals who are neither a Preferred Provider nor a Contracting Provider render services. These excess charges could amount to thousands of dollars in additional out of pocket expenses to the Covered Person.

ELIGIBILITY STANDARDS, Subsections 6.1.4, and 6.1.5 are hereby amended to read as follows:

4. Proof of Mental Retardation or Physical Disability. In order for Dependent coverage to be provided due to mental retardation or physical disability, proof of the Child's dependency and retardation or disability must be furnished to the Company prior to the Child's attainment of the applicable limiting age referenced in sections 6.1.2.b. and 6.1.2.c. above. Such proof must at least demonstrate that the Child is unable to obtain or continue a job or position in the course of commerce and that his or her parent(s) are providing 50% or more of his financial support (i.e. are declaring the Child as a dependent on their federal income tax return.) Subsequent evaluation for continued retardation or physical disability and dependency may be required by the Company, but not more frequently than once per year. An Employee who first becomes eligible under the Plan may enroll a retarded or disabled Dependent Child provided the retardation or disability commenced before the limiting age, and the Child has been continuously covered under a health benefit plan as a Dependent of the Employee since before attaining the limiting age. The Company's determination of eligibility shall be conclusive.

5. Student Coverage, Conditions and Verification.
   a. When a Dependent is eligible for coverage on a student basis as set forth in this Benefit Certificate, coverage is conditioned upon continued student status and documentation of such status.
   b. A Child is expected to be enrolled for 12 accredited academic semester hours, or the academic institution's equivalent full time academic load, to qualify for student dependency coverage.
   c. If an acute illness (an illness lasting less than six months) prevents a Child from maintaining the academic institution's full-time academic load, the Child may still maintain student dependency coverage for the current full academic semester or academic term, if
such Child or the Employee provides the Company with a letter from the Child's attending physician, which attests to the acute illness and disability resulting from such illness. In order to continue student dependency coverage after the end of the covered semester or academic term, the Employee must submit a new student verification form indicating that his or her Child will attend the next semester or academic term and maintain a full-time academic load.

d. If a chronic illness (an illness lasting six or more months) prevents a Child from maintaining 12 accredited academic semester hours, or the academic institution's equivalent full time academic load, the Child may still maintain student dependency coverage if the student maintains at least six (6) to eleven (11) hours (fifty (50%) or more of full-time academic load) toward an academic degree. The Child must provide the Company with a letter from the Registrar or other appropriate official of the academic institution indicating active student status and degree candidacy, as well as a letter from the Child's attending physician attesting to the chronic illness and the effect of the chronic illness on the Child's enrollment status, in order to continue coverage.

e. The Employee and Dependent are each responsible for notifying the Company of a change in student status of a Child; however, the Company may request proof of student status each school term.

f. Both the Employee and the Dependent are obligated to respond promptly and fully to any request to verify student status from the Company. Both the Employee and Dependent agree to authorize any school office or representative to release to the Company all information the Company may request concerning the Dependent's enrollment, academic or disciplinary record, attendance record and continued student status.

g. The Dependent's coverage may be terminated by the Company if the Company is unable to verify continued student status as required within 30 days, or if either the Employee or Dependent fails to promptly respond to inquiries from the Company within 30 days, or fails to authorize release of any information to the Company. The coverage will be terminated regardless of the Dependent's actual student status. If the student's coverage terminated due to a failure to notify or respond to the Company's inquiries, the new effective date of student coverage will be the first of the Policy Month following acceptance by the Company of the appropriate certifications of student status.

h. Except as provided in Subsection 6.1.5.c. above, if a Dependent covered as a student ceases to be enrolled and ceases to regularly attend on-campus classes, all coverage under this Benefit Certificate shall terminate on the earliest to occur of (i) the date on which the Dependent formally withdrew from school enrollment; or (ii) the date on which the Dependent notified any school office or official that the Dependent intended to withdraw or cease attendance; or (iii) the date on which the Dependent or any parent, guardian or representative of the Dependent was notified by the school that enrollment as a student would be terminated, suspended or placed on administrative hold or probation; or (iv) the date on which the Dependent leaves or abandons school or fails to meet minimal school attendance standards or testing requirements for continued enrollment as a full-time student; or (v) the date on which the Dependent last attended any classes prior to the occurrence of any of the events described in the preceding four subparagraphs (i), (ii), (iii) or (iv) of this paragraph (e).

i. If a question is raised as to a Dependent's student status, the Company may withhold processing or payment of any claim, pending the outcome of the Company's investigation and verification of student status. Claims for services received after a Dependent ceases to be enrolled and regularly attending on-campus classes under any of the conditions outlined in paragraph e. above, are not covered and shall be denied by the Company, regardless of when the Company learns of the termination of student status. If the Company has processed or paid any claims before learning that student status terminated, Employee and Dependent agree to cooperate fully with the Company in recovering any such payments from Providers, and, if such amounts are not promptly refunded to the Company, Employee and Dependent agree to reimburse the Company the full amount of any such payments.

ELIGIBILITY STANDARDS, Subsection 6.4.3.b. is hereby amended to read as follows:

Requirements for COBRA Continuation. Continuation under this Subsection is subject to a Covered Person requesting it and paying any required premium contributions to the Group within the applicable COBRA election period. In addition, all of the following conditions must be satisfied in order for COBRA continuation coverage to apply:
i. The Group must sponsor and maintain the Plan at the time of the qualifying event, as well as when the Covered Person elects to continue coverage; and

ii. The Group, as Plan Administrator, must have provided the Covered Person an initial notice of COBRA rights at the time coverage commenced under the Plan (this Benefit Certificate); and

iii. The Plan Administrator must notify the person qualified to elect continuation of coverage under COBRA ("Qualified Insured") of the right to elect coverage within 14 days of receiving notice of the happening of any of the qualifying events listed above; and

iv. The Covered Person must notify the Plan Administrator within 60 days of the happening of Qualifying Event (iii) or (v) in Section 6.4.3.a, above; and

v. The Covered Person must elect to continue coverage under the Plan within 60 days of the later of:
   (1) the date the notification of election rights is sent, or
   (2) the date coverage under the Plan terminates.

If an election is not made by the Covered Person within this 60-day period, the option to elect COBRA shall end.

If an Employee with Dependent coverage requests continuation of coverage under this Section, such request shall include the Dependent coverage, unless the Employee asks that it be dropped. In like manner, such a request on the part of the covered Spouse of a Covered Person shall include coverage for all Dependents of the Employee who were covered.

ELIGIBILITY STANDARDS, Subsections 6.5.3, is hereby amended to read as follows:

Written Application Deadline. In order to obtain a Conversion Plan, written application to convert and payment of applicable premium charges must be submitted to the Company within 30 days following the date on which the Company sends the Covered Person a notice of termination of coverage.

CLAIM PROCESSING AND APPEALS, Subsection 7.2.8 is hereby amended to read as follows:

Notification of Determination of Appeal to Plan. The Appeals Coordinator shall provide notice of the review determination in a printed form and written in a manner calculated to be understood by the claimant. The notice shall include:

a. The specific reason or reasons for the review determination;

b. reference to the specific plan provision(s) on which the review determination is based;

c. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information Relevant to the Claim for benefits;

d. a statement that any internal rule, guideline, protocol or other similar criterion relied upon by the Plan is available upon request and free of charge;

e. a statement describing the voluntary external review procedures offered by the Plan; and

f. a statement of the claimant's right to bring an action under the Employee Retirement Income Security Act of 1974.

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

Sharon Allen, President
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