AMENDMENT

issued by

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

to

VENTURA COUNTY COMMUNITY COLLEGE DISTRICT

ASCC

Anthem Blue Cross Life and Health Insurance Company ("Anthem Blue Cross Life and Health") agrees to modify your certificate by this amendment. The modifications described in this amendment are state-specific as indicated and apply only to insured persons residing in those states. All other provisions of the certificate which are not inconsistent with this amendment remain in effect. Officers of Anthem Blue Cross Life and Health have approved this amendment to become effective July 1, 2012.

FOR INSURED PERSONS RESIDING IN ARKANSAS

Item 2 under the Dental Care benefit under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is deleted and replaced by the following:

2. General Anesthesia. General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a hospital or ambulatory surgical center. This applies only if (a) the insured person is less than seven years old, (b) the insured person is developmentally disabled, (c) the insured person has a significant behavioral problem as determined by the insured person's physician, or (d) the insured person's health is compromised and general anesthesia is medically necessary. Charges for the
dental procedure itself, including professional fees of a dentist, are not covered.

The following **In Vitro Fertilization Treatment** benefit is added:

**In Vitro Fertilization Treatment.** Outpatient services and supplies provided in connection with in vitro fertilization procedures performed on you provided that:

1. Your oocytes are fertilized with your *spouse’s* sperm; and

2. You and your present *spouse* have at least a two *year* history of infertility, or the infertility is related to one or more of the following medical conditions:
   a. endometriosis;
   b. exposure in utero to diethylstilbestrol (DES);
   c. blockage of, or surgical removal of, one or both fallopian tubes; or
   d. abnormal male factors contributing to the infertility; and

3. You have been unable to attain a successful pregnancy through less costly infertility treatments; and

4. The procedures are performed at a medical facility that meets (a) the American College of Obstetric and Gynecology guidelines or infertility clinics; or (b) the American Fertility Society’s minimal standards for infertility programs.

The *maximum allowed amount* will not include charges if: (1) the infertility resulted from voluntary sterilization; or (2) the embryo is implanted for any period of time in a woman other than the *insured person*.

The Deductibles, Co-Payments and Out-Of-Pocket provisions will be the same as for any other illness, injury or condition, but in no event will benefit payments exceed **$15,000** for all covered charges incurred during your lifetime.

*Drugs* used primarily for in vitro fertilization procedures are covered under **YOUR PRESCRIPTION DRUG BENEFITS**. The exclusion of *drugs* used primarily for the purpose of treating infertility will not apply with respect to *drugs* used primarily for in vitro fertilization procedures.
FOR INSURED PERSONS RESIDING IN COLORADO

The Well Baby and Well Child Care benefit described in the certificate is extended to dependent children under age 13. The Physical Exam benefit described in the certificate will apply to insured persons age 13 and over.

The Well Baby and Well Child Care provision in YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is edited to cover the listed preventive care services for dependent children under 13 years of age.

FOR INSURED PERSONS RESIDING IN CONNECTICUT

This amendment applies to your certificate only if 51% or more of the employees of the group reside in Connecticut.

The following provisions are added to the SUMMARY OF BENEFITS: DEDUCTIBLES under the Exceptions section:

- The Calendar Year Deductible will not apply to benefits for Early Intervention Services.
- The Calendar Year Deductible will not apply to Home Health Care services. An insured person will be required to satisfy a Home Health Care Deductible of $50 each year.
- The Calendar Year Deductible will not apply to benefits for Testing for Bone Marrow Transplants.

The following provisions are added to the SUMMARY OF BENEFITS: CO-PAYMENTS under the Exceptions section:

1. There will be no Co-Payment for Early Intervention Services.
2. The Co-Payment for Testing for Bone Marrow Transplants shall not exceed 20% of the cost for such testing.
3. The following Co-Payment maximums will apply to Diagnostic Services provided by a participating provider:
1. Magnetic Resonance Imaging (MRI) or Computed Axial Tomography (CAT) Co-Payments shall not exceed $75 per service. The combined annual Co-Payment for all MRI and CAT imaging services shall not exceed $375.

2. Positron Emission Tomography (PET) Co-Payments shall not exceed $100 per service. The combined annual Co-Payment for all PET imaging services shall not exceed $400.

The following provisions are added to YOUR MEDICAL BENEFITS:

1. The **Prosthetic Devices** provision under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is revised to include coverage for wigs when required as a result of hair loss due to the treatment of any form of cancer or leukemia. Any exclusion for scalp hair prostheses or wigs will not apply in this situation only.

2. **Oral Anti-Cancer Medications.** Orally administered anti-cancer medications used to kill or slow the growth of cancerous cells, that are prescribed by a licensed prescriber. These medications shall be covered on a basis that is no less favorable than for intravenously administered anti-cancer medications.

3. **Early Intervention Services.** In addition to any other benefits provided under the plan, medically necessary early intervention services are provided for a dependent child from birth up to three years of age, subject to the following:

   1. A referral from a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided is required.

   2. Coverage is generally limited to $6,400 per year, not to exceed $19,200 by the child's third birthday. For children with autism spectrum disorders, coverage is limited to $50,000 per year, not to exceed $150,000 by the child's third birthday.

   3. Coverage is subject to all other provisions of the plan.

“Early intervention services” means services provided by licensed occupational therapists, physical therapists, speech pathologists, or clinical social workers working with children from birth to age 36 months with an identified developmental disability or delay, as measured by both diagnostically appropriate instruments and procedures, in one or more of the following areas: cognitive development, physical development (including vision and hearing),
communication development, social or emotional development, and adaptive development. Also included are children with a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay, with the condition being such that the child needs early intervention services.

4. **Epidermolysis Bullosa.** In addition to any other benefits provided under this plan, medically necessary treatment and wound-care supplies related to the treatment of epidermolysis bullosa.

5. The Special Food Products provision is deleted and replaced by the following:

   **Special Food Products.** Special food products and formulas that are part of a diet prescribed by a physician for the treatment of phenylketonuria (PKU). Most formulas used in the treatment of PKU are obtained from a pharmacy and are covered under your plan’s prescription drug benefits (see YOUR PRESCRIPTION DRUG BENEFITS). Special food products that are not available from a pharmacy are covered as medical supplies under your plan’s medical benefits.

   In addition to the special food products and formulas described above, benefits are provided for specialized formula to children up to age 12 that is intended for use solely under the medical supervision of a physician in the dietary management of specific diseases or conditions.

6. **Infertility Services.** The following services and supplies furnished in connection with the diagnosis and treatment of infertility, when under the direct care and treatment of a physician:

   1. Examinations.
   2. Diagnostic tests and work-ups.
   3. Medications administered in a physician’s office.
   4. Reconstructive surgery, except for sterilization reversal.
   5. Supplies and appliances.

   The services and supplies furnished in connection with infertility procedures, including, but not limited to:

   1. In vitro fertilization (IVF) up to 2 cycles, with not more than 2 embryo implantations per cycle, per the insured person’s lifetime,
2. Zygote intra-fallopian transfer (ZIFT) up to 2 cycles, with not more than 2 embryo implantations per cycle, per the insured person’s lifetime,

3. Gamete intra-fallopian transfer (GIFT) up to 2 cycles, with not more than 2 embryo implantations per cycle, per the insured person’s lifetime,

4. Cryopreserved embryo transfers,

5. Intracytoplasmic sperm injection (ICSI),

6. Ovulation induction up to 4 cycles per the insured person’s lifetime,

7. Intrauterine insemination up to 3 cycles per the insured person’s lifetime, and

8. Low tubal ovum transfer up to 2 cycles, with not more than 2 embryo implantations per cycle, per the insured person’s lifetime.

Benefits are provided for infertility services for insured persons up to age 40 who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered through such policy.

(Note: For benefits for drugs prescribed for the treatment of infertility, see the section entitled YOUR PRESCRIPTION DRUG BENEFITS.)

7. Testing for Bone Marrow Transplants. Human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens for utilization in bone marrow transplantation.

Testing must be performed in a facility that is accredited by the American Society for Histocompatibility and Immunogenetics, or its successor, and certified under the Clinical Laboratory Improvement Act of 1967. Insured persons will be required to participate in National Marrow Donor Program.

The provision for Diagnostic Services in YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is deleted and replaced by the following:
Diagnostic Services. Outpatient diagnostic imaging and laboratory services. Imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and nuclear cardiac imaging are subject to pre-service review to determine medical necessity. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review. See UTILIZATION REVIEW PROGRAM for details.

Magnetic Resonance Imaging (MRI) or Computed Axial Tomography (CAT) Co-Payments shall not exceed $75 per service. The combined annual Co-Payment for all MRI and CAT imaging services shall not exceed $375. Positron Emission Tomography (PET) Co-Payments shall not exceed $100 per service. The combined annual Co-Payment for all PET imaging services shall not exceed $400.

The exclusion for Outpatient Prescription Drugs and Medications under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED is revised to include an exception for “Oral Anti-Cancer Medications”.

The following exclusion is added to the section YOUR PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED:

Oral anti-cancer medications. While not covered under this prescription drug benefit, these items are covered under the “Oral Anti-Cancer Medications” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this plan that apply to those benefits.

The exclusion for Infertility Treatment under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED is revised as follows:

Infertility Treatment. Services or supplies furnished in connection with the diagnosis and treatment of infertility, except as specifically stated in the “Infertility Treatment” provision of MEDICAL CARE THAT IS COVERED.
The following exclusion is removed from the section **YOUR PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED:**

Drugs used primarily for the purpose of treating infertility, unless medically necessary for another covered condition.

The **Important Note for Newborn and Newly-Adopted Children** in the **EFFECTIVE DATE** provision under the **HOW COVERAGE BEGINS AND ENDS** section is deleted and replaced by the following:

**Important Note for Newborn and Newly-Adopted Children.** If the insured employee (or spouse or domestic partner, if the spouse or domestic partner is enrolled) is already covered: (1) any child born to the employee, spouse or domestic partner will be enrolled from the moment of birth; and (2) any child being adopted by the employee, spouse or domestic partner will be enrolled from the date on which either: (a) the adoptive child’s birth parent, or other appropriate legal authority, signs a written document granting the employee, spouse or domestic partner the right to control the health care of the child (in the absence of a written document, other evidence of the employee’s, spouse’s or domestic partner’s right to control the health care of the child may be used); or (b) the employee, spouse or domestic partner assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child’s adoption. The ‘written document’ referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

In both cases, coverage will be in effect for 61 days. For coverage to continue beyond this 61-day period, the employee must submit a membership change form to the group within the 61-day period. We must then receive the form from the group within 90 days.

The **Timely Payment of Claims** provision in the **GENERAL PROVISIONS** section is deleted and replaced by the following:

**Timely Payment of Claims.** Any benefits due under this plan shall be due once we have received proper, written proof of loss, together with such reasonably necessary additional information we may require to determine our obligation.
Claims filed in paper format will be paid within 60 days of receipt of the Proof of Loss. If the claim does not include all required information, you will receive notice requesting the necessary additional information within 30 days. The claim will then be paid within 30 days of receipt of the requested information. Claims filed electronically will be paid within 20 days of receipt of the Proof of Loss. If the claim does not include all the required information, you will receive notice requesting the necessary additional information within 10 days. The claim will then be paid within 10 days of receipt of the requested information.

The following STATE CONTINUATION OF HEALTH INSURANCE COVERAGE is added to your certificate:

STATE CONTINUATION OF HEALTH INSURANCE COVERAGE

If your coverage terminates, you, your spouse, and/or your unmarried children age 25 or younger, will have the right to continue your coverage under this policy under the circumstances outlined below. Check with your employer for details.

1. Upon your layoff, reduction of hours, leave of absence, or termination, for reasons other than “gross misconduct,” for a period of up to 30 months, or until you and/or your dependents become eligible for benefits under Medicare (Title XVIII of the Social Security Act);

2. If your covered dependents’ coverage under this plan ends as a result of your death, for the period of time established by the Consolidated Omnibus Reconciliation Act of 1985 (COBRA); or

3. During your absence due to illness or injury for up to 12 months from the date of the illness or injury.

Cost of Coverage. The cost of the insured person’s continuation coverage will be 102% of the applicable group rate. The insured person must pay this cost directly to us.

When Continuation Ends. This continuation will end on the earliest of:

1. The end of the period for which premiums were last paid;

2. The expiration of time frames listed above; or
3. Midnight of the day preceding the insured person’s eligibility for Medicare if the insured person’s reduced hours, leave of absence, or termination of employment results from his or her eligibility for Social Security Income.

The DEFINITIONS section is amended by the following:

1. The definition of “Physician” is changed to include the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in the certificate, and when benefits would be payable if the services were provided by a doctor of medicine (M.D.) or doctor of osteopathy (D.O.):
   1. A certified nurse practitioner
   2. A physician’s assistant

2. The definition of “medically necessary” is replaced by the following definition:

   Medically necessary or “medical necessity” means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

   1. In accordance with generally accepted standards of medical practice;
   2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
   3. Not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

   For the purposes of this definition, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.
3. The definition of “hospital” is changed to include “Mobile field hospital.”

FOR INSURED PERSONS RESIDING IN DELAWARE

The Prosthetic Devices provision under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is revised to include coverage for scalp hair prosthesis for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease.

The following provisions are added to the Exception to rule 3 under the COORDINATION OF BENEFITS: ORDER OF BENEFITS DETERMINATION:

d. Upon request by either parent of a dependent child, an insurance card showing proof of coverage for the dependent child will be issued to the parent making the request.

e. If benefits of This Plan are not assigned to the provider and would be paid to someone other than the provider, the benefits will be paid to the parent who sought the treatment for the dependent child.

With respect to coverage for substance abuse provided under the plan, the term “physician” in the DEFINITIONS section includes a certified drug and alcohol counselor.

FOR INSURED PERSONS RESIDING IN DISTRICT OF COLUMBIA

Wherever the term “cancer clinical trials” appears in the certificate booklet, it is changed to “approved clinical trials”.

The Cancer Clinical Trials provision is deleted and replaced by the following:

Approved Clinical Trials. Coverage is provided for services and supplies for routine patient care costs in connection with approved clinical trials if all of the following conditions are met:

1. You are eligible to participate in an approved clinical trial; and
2. The approved clinical trial is undertaken for the purposes of the prevention, early detection, treatment, or monitoring of cancer, chronic disease, or life-threatening illness.

For the purposes of this provision, “routine patient costs” does not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial involved. It does not include the costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

An “approved clinical trial” means:

1. A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
   a. The National Institutes of Health;
   b. The Centers for Disease Control and Prevention;
   c. The Centers for Medicare and Medicaid Services;
   d. A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or
   e. The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;

2. A study or investigation approved by the Food and Drug Administration (FDA), including those conducted under an investigational new drug or device application reviewed by the FDA; or

3. An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services.

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE.
The definition of “Child” in the Eligible Status provision under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS shall include the insured employee’s, spouse’s or domestic partner’s grandchild, niece or nephew, if such grandchild, niece or nephew is under the primary care of the employee, spouse or domestic partner and the legal guardian of the child, who is other than the employee, spouse or domestic partner, is not covered under a health policy. “Primary care” means that the employee, spouse or domestic partner provides food, clothing and shelter on a regular and continuous basis for the child during the time public schools are in regular session.

The DEFINITIONS section is amended by the following:

1. The definition of “day treatment center” is deleted and of no further effect.

2. The following definition is added:

   **Outpatient treatment facility** is a clinic, counseling center, or other similar location that is certified by the District of Columbia or by any state or territory as a qualified provider of outpatient services for the treatment of substance abuse or mental or nervous disorders. It also includes any facility operated by the District of Columbia, any state or territory, or the United States to provide these services on an outpatient basis.

**FOR INSURED PERSONS RESIDING IN FLORIDA**

The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

Item 2, **General Anesthesia** under the Dental Care benefit in the YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED section is deleted and replaced by the following:

2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a hospital or ambulatory surgical center. This applies only if (a) the insured person is less than eight years old, (b) the insured person is developmentally disabled, or (c) the insured person’s health is compromised and general anesthesia is medically necessary.
Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

The following exception is added to the EXTENSION OF BENEFITS section:

Exception: If you are pregnant on the date of discontinuance of the policy, your pregnancy and maternity care benefits under this plan will be continued subject to the following:

1. Your pregnancy began while the policy was in effect.
2. You do not have to be totally disabled.
3. Your extension of benefits will end when you are no longer pregnant.

The definition of “Physician” in the DEFINITIONS section is changed to include a registered nurse first assistant (R.N.) in the list of providers recognized when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in the certificate, and when benefits would be payable if the services were provided by a doctor of medicine (M.D.) or doctor of osteopathy (D.O.).

FOR INSURED PERSONS RESIDING IN GEORGIA

Item 2, General Anesthesia under the Dental Care benefit in the YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED section is deleted and replaced by the following:

2. General Anesthesia. General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a hospital or ambulatory surgical center. This applies only if (a) the insured person is less than seven years old, (b) the insured person is developmentally disabled, (c) the insured person’s health is compromised and general anesthesia is medically necessary or (d) the insured person has suffered extensive facial or dental trauma. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.
FOR INSURED PERSONS RESIDING IN KANSAS

With respect to covered treatment of mental or nervous disorders or substance abuse, you will not be required to pay a Co-Payment for the first $100 of covered outpatient services and your Co-Payment for the second $100 of covered outpatient services will not exceed 20% of the maximum allowed amount. The Calendar Year Deductible will not apply to the first $100 of covered outpatient services for treatment of mental or nervous disorders or substance abuse.

The PRE-EXISTING CONDITION EXCLUSION is deleted and replaced by the following:

PRE-EXISTING CONDITION EXCLUSION

No payment will be made for services or supplies for the treatment of a pre-existing condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 90-day period prior to your coverage under this plan. Generally, this 90-day period ends the day before your coverage becomes effective. However if you were subject to a waiting period for coverage, the 90-day period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy, to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption, nor to an insured person who is under age 19.

This exclusion may last up to 90 days from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period (see "Eligibility Date" under the section HOW COVERAGE BEGINS AND ENDS). However, you can reduce the length of this exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a significant break in coverage. The maximum allowable break in coverage is 180 days if your prior coverage was provided through an employer and ended because your employment (or the person's employment through whom you had this coverage) ended, the availability of coverage through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated. For prior coverage that was not provided through an employer, such as individual coverage or coverage through a government program such as Medicaid, the
maximum allowable break in coverage is 63 days. Please see "Creditable Coverage" in the DEFINITIONS section for a complete list of the types of coverage for which credit is given.

To reduce the 90-day exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. There is no time limit within which you must provide a certificate in order to receive credit for your prior coverage. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or carrier. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage. All questions about the pre-existing condition exclusion and creditable coverage should be directed to the customer service telephone number listed on your identification card.

The following changes are made to the DEFINITIONS section:

1. The definition of "Physician" is changed to include an advanced registered nurse practitioner (R.N.) in the list of providers recognized when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in the certificate, and when benefits would be payable if the services were provided by a doctor of medicine (M.D.) or doctor of osteopathy (D.O.).

2. The definition of "Pre-existing condition" is deleted and replaced by the following:

   Pre-existing condition means an illness, injury or condition which existed during the 90-day period immediately prior to either (a) your effective date or (b) the first day of any waiting period required by the group, whichever is earlier. A condition is considered to have existed when you: (1) sought or received medical advice for that condition; (2) received medical care or treatment for that condition; or (3) received medical supplies, drugs or medicines for that condition.
FOR INSURED PERSONS RESIDING IN LOUISIANA

The maximum allowed amount for a non-participating provider dentist for services and supplies provided in connection with the “Dental Care” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED, will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a participating provider dentist. Your Co-Payment for such services of a non-participating provider dentist will be the same as the Co-Payment that would apply to a participating provider dentist.

The Cancer Clinical Trials provision under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is deleted and replaced by the following:

Cancer Clinical Trials. Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials if all of the following conditions are met:

1. The treatment provided in a clinical trial must be approved by:
   a. one of the National Institutes of Health,
   b. a cooperative group funded by one of the National Institutes of Health,
   c. the federal Food and Drug Administration in the form of an investigational new drug application,
   d. the United States Department of Defense,
   e. the United States Veteran’s Administration,
   f. a federally funded general clinical research center, or
   g. the Coalition of National Cancer Cooperative Groups.

2. For the purpose of this provision, a clinical trial must have a therapeutic or palliative intent.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the plan, including health care services which are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.

3. Clinically appropriate monitoring of the investigational item or service.

4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.

5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs does not include any of the items listed below. You will be responsible for the costs associated with any of the following, in addition to the costs of non-covered services.

1. *Drugs* or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.

2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.

3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.

4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the plan.

5. Health care services customarily provided by the research sponsors free of charge to insured persons enrolled in the trial.

The **REIMBURSEMENT FOR ACTS OF THIRD PARTIES** provisions are deleted and replaced by the following:

**REIMBURSEMENT FOR ACTS OF THIRD PARTIES**

Under some circumstances, an *insured person* may need services under this *plan* for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, we will provide the benefits of this *plan* subject to the following:

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or
otherwise, that you receive from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits we paid under this plan for the treatment of the illness, disease, injury or condition for which the third party is liable.

2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your plan. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this plan and will result in your being personally responsible for reimbursing us.

3. We will be entitled to collect on our lien only if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is the full amount of the actual loss you suffered. We will pay our portion of your attorney's fees or other costs associated with a claim or lawsuit to the extent that we recover any portion of the benefits provided under this plan according to these provisions.

The BINDING ARBITRATION provision in your certificate booklet is deleted and of no effect.

FOR INSURED PERSONS RESIDING IN MAINE

Wherever the term “cancer clinical trials” appears in the certificate booklet, it is changed to “approved clinical trials”.

The following changes are made under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED section:

1. The following item is added to the Prosthetic Devices provision:

   4. Repair or replacement of a prosthetic device if repair or replacement is determined appropriate by your provider.

2. Item 2 of the Dental Care provision is deleted and replaced by the following:
2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a hospital or ambulatory surgical center. This applies only if:

   a. the *insured person* has a physical, intellectual or medically compromising condition for which dental treatment under local anesthesia cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result;

   b. the *insured person* has dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

   c. the insured dependent *child* is extremely uncooperative, fearful, anxious or uncommunicative and has dental needs of such a degree that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; or

   d. the *insured person* has extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

3. The **Cancer Clinical Trials** provision is deleted and replaced by the following:

   **Approved Clinical Trials.** Coverage is provided for services and supplies for routine patient care costs in connection with approved clinical trials if all of the following conditions are met:

   1. You have a life-threatening illness for which no standard treatment is effective;

   2. You are eligible to participate according to the clinical trial protocol with respect to treatment of such illness;

   3. Your participation has a meaningful potential to benefit you; and

   4. Your *physician* has concluded that your participation would be appropriate based upon the satisfaction of the above conditions.

   For the purposes of this provision, “routine patient costs” does not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial involved. It does not include the
costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

An “approved clinical trial” means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.

For payment for non-participating providers, the cost will be based on the lesser of the billed charge or the amount that ordinarily applies when services are provided by a participating provider.

4. The Special Food Products provision is deleted and replaced by the following:

**Special Food Products.** Special food products and formulas that are part of a diet prescribed by a physician for the treatment of phenylketonuria (PKU). Most formulas used in the treatment of PKU are obtained from a pharmacy and are covered under your plan’s prescription drug benefits (see YOUR PRESCRIPTION DRUG BENEFITS). Special food products that are not available from a pharmacy are covered as medical supplies under your plan’s medical benefits.

In addition to the special food products and formulas described above, benefits are provided for other amino acid-based elemental infant formula for children two years of age and under when a licensed physician has submitted documentation that the amino-acid based elemental infant formula is medically necessary, the formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated.

Benefits are provided for amino acid-based elemental infant formula when a licensed physician has diagnosed and through medical evaluation has documented one of the following conditions:

A. Symptomatic allergic colitis or proctitis;
B. Laboratory or biopsy-proven allergic or eosinophilic gastroenteritis;
C. A history of anaphylaxis;
D. Gastroesophageal reflux disease that is nonresponsive to standard medical treatment;
E. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider;
F. Cystic fibrosis; or
G. Malabsorption of cow milk-based or soy milk-based infant formula.

Most amino acid-based elemental infant formulas are obtained from a pharmacy and are covered under your plan’s prescription drug benefits (see YOUR PRESCRIPTION DRUG BENEFITS). Any formulas that are not available from a pharmacy are covered as medical supplies under your plan’s medical benefits.

5. The following provision is added:

**Early Intervention Services.** In addition to any other benefits provided under the plan, medically necessary early intervention services are provided for a dependent child from birth through three years of age, subject to the following:

1. A referral from a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided is required.

2. Coverage is limited to $3200 per year, not to exceed $9600 by the child’s third birthday.

3. Coverage is subject to all other provisions of the plan, including applicable exclusions, limitations, deductibles, and copayments.

“Early intervention services” means services provided by licensed occupational therapists, physical therapists, speech pathologists, or clinical social workers working with children from birth to age 36 months with an identified developmental disability or delay, as measured by both diagnostically appropriate instruments and procedures, in one or more of the following areas: cognitive development, physical development (including vision and hearing), communication development, social or emotional development, and adaptive development. Also included are children with a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay, with the condition being such that the child needs early intervention services.
The following **STATE CONTINUATION FOR QUALIFYING INSURED PERSONS** is added to your certificate:

**STATE CONTINUATION FOR QUALIFYING INSURED PERSONS**

Subject to payment of premium as stated in the policy, coverage under this plan may be continued for you, you and your covered dependents, or for your covered dependents only, in accordance with the terms and conditions explained below, if and only if this group policy is **not** subject to the United States Consolidated Omnibus Reconciliation Act of 1985 (COBRA), Title X of P.L. 99-272.

If your coverage under this plan ends for any of the reasons listed below, you may elect to continue coverage under this plan, at your own expense, or at your option, to apply for coverage under a medical conversion plan without evidence of insurability. You are eligible to continue coverage under this provision if your coverage ends for one of the following reasons:

1. You are temporarily laid off from employment,
2. You are permanently laid off from employment and are eligible for premium assistance pursuant to federal law providing premium assistance for laid-off employees who continue coverage under their former employer’s plan, or
3. Your employment ends because of an injury or illness you claim to be compensable under applicable worker’s compensation laws.

You must elect continuation coverage and make the initial premium payment within 31 days from the date your coverage under the plan ends. The premium for continuation coverage under this provision will be 102% of the applicable group rate. You may elect to continue coverage for yourself only, for yourself and any dependents who were covered with you under the plan, or only for any covered dependents. You must have been covered under the plan for at least six months prior to the date you lost coverage; any dependents for whom continuation coverage is elected must have been covered under the plan for at least three months prior to the date coverage is lost, unless the dependent was not eligible for coverage until after the beginning of the three month period.

Continuation coverage under this provision will end when the earliest of the following events occurs:

1. The date that is one year from your last day of employment.
2. You do not make timely payment of the required premium.

3. You become eligible for coverage under another group plan.

4. The worker’s compensation board determines that the injury or illness entitling you to continue coverage is not compensable.

5. The date the policy terminates.

6. The date the group no longer provides coverage to the class of employees to which you belong.

If your continuation under this plan ends in accordance with items 1, 4, 5, or 6 above, you are eligible for medical conversion coverage.

The definition of “physician” in the DEFINITIONS section includes the following:

- A certified nurse practitioner
- A registered nurse first assistant
- A licensed independent practice dental hygienist

With respect to coverage for mental or nervous disorders provided under the plan, the term “physician” in the DEFINITIONS section includes the following:

- A licensed clinical professional counselor
- A licensed nurse certified as a clinical specialist in child adolescent psychiatric and mental health nursing
- A licensed pastoral counselor

FOR INSURED PERSONS RESIDING IN MARYLAND

The Special Food Products benefit under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is deleted and replaced by the following:

Special Food Products. Special food products and formulas that are part of a diet prescribed by a physician for the treatment of the following diseases or disorders:

1. Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;

2. Severe food protein induced enterocolitis syndrome;
3. Eosinophilic disorders, as evidenced by the results of a biopsy; and

4. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Most formulas used in the treatment of the above diseases are obtained from a pharmacy and are covered under your plan’s prescription drug benefits (see YOUR PRESCRIPTION DRUG BENEFITS). Special food products that are not available from a pharmacy are covered as medical supplies under your plan’s medical benefits.

FOR INSURED PERSONS RESIDING IN MASSACHUSETTS

The following is added to the Medical Benefit Maximums under MEDICAL BENEFITS in the SUMMARY OF BENEFITS section:

Early Intervention Services for Dependent Child Under Age 3

- All services delivered by early intervention specialists..............................................$5,200 per year per child

The Pregnancy and Maternity Care benefit under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is replaced by the following:

Pregnancy and Maternity Care

1. All medical benefits for an enrolled insured person when provided for pregnancy or maternity care, including the following services:

   a. Prenatal and postnatal care;

   b. Ambulatory care services (including ultrasounds, fetal non-stress tests, physician office visits, and other medically necessary maternity services performed outside of a hospital);

   c. Involuntary complications of pregnancy;

   d. Diagnosis of genetic disorders in cases of high-risk pregnancy; and
e. Inpatient hospital care including labor and delivery.

Inpatient hospital benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her physician decide on an earlier discharge. Please see the section entitled FOR YOUR INFORMATION for a statement of your rights under federal law regarding these services.

2. Medical hospital benefits for routine nursery care of a newborn child, if the child's natural mother is an insured person. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases provided through a program established by law or regulation.

The following provision is added to MEDICAL CARE THAT IS COVERED in the YOUR MEDICAL BENEFITS section:

**Infertility Treatment.** Services and supplies provided in connection with infertility procedures, provided that:

1. The infertility procedure is non-experimental. Such procedures include, but are not limited to: (a) artificial insemination; (b) in vitro fertilization and embryo placement; and (c) sperm, egg and/or inseminated egg procurement, processing and banking, to the extent such charges are not covered by the donor's own coverage.

2. The insured person is presumably otherwise healthy but is unable to conceive or produce conception during a period of at least one year prior to the beginning of treatment.

3. The procedures are performed at a medical facility that meets (a) the American College of Obstetric and Gynecology guidelines or infertility clinics; or (b) the American Fertility Society's minimal standards for infertility programs.

The maximum allowed amount will not include charges if: (1) the infertility resulted from voluntary sterilization; (2) the embryo is implanted for any period of time in a woman other than the insured person; or (3) the procedure is experimental.

The Pre-Existing Condition Exclusion will not apply to this Infertility Treatment benefit.
The following provision is added to MEDICAL CARE THAT IS COVERED in the YOUR MEDICAL BENEFITS section:

**Early Intervention Services for Dependent Child Under Age 3**

In addition to the benefits provided under the plan, coverage is provided for medically necessary early intervention provided by certified early intervention specialists. Early intervention services are provided to a child who has a disabling physical or mental condition, who shows developmental delays or who is at risk for developmental delays.

Early intervention services are provided by early intervention specialists who are certified by the Massachusetts Department of Public Health and who are working in early intervention programs certified by the Department of Public Health.

Such services will be limited to $5,200 per year per child and are not covered beyond the child’s third birthday.

YOUR PRESCRIPTION DRUG BENEFITS section is changed to include drugs used primarily for the purpose of treating infertility under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED.

The following changes are made under the HOW COVERAGE BEGINS AND ENDS section:

1. The following provision is added to HOW COVERAGE BEGINS:

   **COVERAGE FOR FORMER SPOUSE**

   Your former spouse is eligible for coverage under this plan in accordance with the terms of the divorce or legal separation judgment.

   To obtain coverage, your former spouse must submit an application to us with a copy of the divorce or legal separation judgment within 31 days after your eligibility date.

   Former spouse means the person who was legally married to you before the divorce or legal separation judgment was issued.

2. The following exception is added to HOW COVERAGE ENDS:

   **Exception for Former Spouse.** Coverage for your former spouse ends on the earliest of the following dates:
1. The date the employee’s coverage ends.

2. The end of the period for which premium has been paid to us on behalf of the former spouse.

3. The date the former spouse remarries.

4. At such time as is provided by the divorce judgment.

5. The date you remarry.

But if you remarry, the former spouse has the right, if the divorce judgment provides, to continue coverage under the policy, subject to the terms of this paragraph, by paying the required premium to the group when due.

The following changes are made to the TERMS OF COBRA CONTINUATION under the CONTINUATION OF COVERAGE section:

1. The following exception is added to the “Cost of Coverage” provision:

   **Exception:** If continuation is due to the employer’s cessation or reduction of business, such employer will pay that part of the cost, if any, normally paid by that employer for the first three months of continuation. Thereafter, you must pay the entire cost of the COBRA continuation coverage if required by the group.

2. The following exception is added to the “When the COBRA Continuation Ends” provision:

   **Exception:** Continuation coverage of a spouse due to divorce or legal separation will terminate on the later of: (a) any of the dates listed under “When the COBRA Continuation Ends”; or (b) at such time as is provided by the divorce or legal separation judgment.

**FOR INSURED PERSONS RESIDING IN MINNESOTA**

This amendment applies to your certificate only if 25 employees or 25% or more of the employees of the group reside in Minnesota.

The **Pregnancy and Maternity Care** benefit under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is replaced by the following:
Pregnancy and Maternity Care

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient hospital benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her physician decide on an earlier discharge.

2. Medical hospital benefits for routine nursery care of a newborn child, if the child’s natural mother is an insured person.

Covered prenatal care services provided under this Pregnancy and Maternity Care benefit will not be subject to any deductibles, co-payments or benefit maximums.

The Chemotherapy benefit under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is replaced by the following:

Chemotherapy. Injected, intravenous, or orally administered chemotherapy.

The following provision is added to YOUR PRESCRIPTION DRUGS: PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

10. Orally administered anticancer drugs used to kill or slow the growth of cancerous cells. While not covered under this prescription drug benefit, these drugs and any professional charges associated with them, are covered as specified under the “Chemotherapy” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED (see Table of Contents), subject to all terms of this plan that apply to those benefits.
The **REIMBURSEMENT FOR ACTS OF THIRD PARTIES** section is deleted and replaced by the following:

**REIMBURSEMENT FOR ACTS OF THIRD PARTIES**

No payment will be made under this plan for expenses incurred for or in connection with any illness, injury, or condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. But we will provide the benefits of this plan subject to the following:

1. We will automatically have a lien, to the extent of benefits provided, upon full recovery, whether by settlement, judgment or otherwise, that you receive from the third party, the third party’s insurer, or the third party’s guarantor. The lien will be in the amount of benefits we paid under this plan for the treatment of the illness, disease, injury or condition for which the third party is liable, reduced by the monies paid to account for the pro rata share of your costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source.

2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your plan. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of this plan and will result in your being personally responsible for reimbursing us.

The definition of “Child” in the “Eligible Status” provision in the **HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS** section is changed to include a grandchild of the insured employee, spouse or domestic partner who depends on the employee, spouse or domestic partner for financial support and has lived with the employee, spouse or domestic partner continuously from birth. The term “newborn” in the “Effective Date” provision will also include a grandchild of the employee, spouse or domestic partner, who is dependent on the employee, spouse or domestic partner for financial support and who has lived with the employee, spouse or domestic partner continuously from birth.
FOR INSURED PERSONS RESIDING IN MISSOURI

The Cancer Clinical Trials provision under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is deleted and replaced by the following:

Cancer Clinical Trials. Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials if all of the following conditions are met:

1. The clinical trial is undertaken for the purposes of the prevention, early detection or treatment of cancer and meet the following conditions:
   a. Involve a drug that is exempt under federal regulations from a new drug application, or
   b. Be approved or funded by (i) one of the National Institutes of Health, (ii) a National Institute of Health Cooperative Group or Center, (iii) the federal Food and Drug Administration in the form of an investigational new drug application, (iv) the United States Department of Defense, (v) the United States Veteran’s Administration, (vi) a qualified research entity that meets the criteria for National Institutes of Health Center support grant eligibility or (vii) an institutional review board in Missouri that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects.

2. In the case of treatment under a clinical trial, the treating facility and personnel must have expertise and training to provide the treatment and treat a sufficient volume of patients.

3. There must be equal to or superior, noninvestigational alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the noninvestigational alternatives.

4. A phase II clinical trial will also be covered if the clinical trial is sanctioned by the National Institutes of Health or the National Cancer Institute and conducted at academic or National Cancer Institute Center; and the insured person is enrolled in the clinical trial.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services.
which would otherwise be covered under the plan, including health care services which are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs does not include any of the items listed below. You will be responsible for the costs associated with any of the following, in addition to the costs of non-covered services.

1. Drugs or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the plan.
5. Health care services customarily provided by the research sponsors free of charge to insured persons enrolled in the trial.
FOR INSURED PERSONS RESIDING IN MONTANA

The following benefits are added to YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED:

Inborn Errors of Metabolism. All medical benefits when provided for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism, for which medically standard methods of diagnosis, treatment and monitoring exist.

Benefits include expenses for diagnosing, monitoring and controlling the disorder by nutritional and medical assessment, including but not limited to, clinical services, biochemical analysis, medical supplies, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used to make up for the metabolic abnormality and to maintain adequate nutritional status.

“Medical foods” means nutritional substances in any form that are:

1. Formulated to be consumed or given enterally under supervision of a physician;
2. Specifically processed or formulated to be distinct in one or more nutrients present in natural food;
3. Intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient needs as determined by medical evaluation; and
4. Needed to improve growth, health and metabolic homeostasis.

The certificate is revised to provide that the services of a physician for pre-commitment psychiatric detention, pre-commitment psychiatric examination, and pre-commitment psychiatric treatment of an insured person as well as any cost associated with testimony during an involuntary commitment proceeding by a physician will be covered subject to the provisions of the certificate.

The following definitions in the DEFINITIONS section should be deleted and replaced by the following:

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of physicians. It must be licensed as a general acute care hospital.
according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

For the limited purpose of inpatient care for the acute phase of a mental or nervous disorder, "hospital" also includes psychiatric health facilities. "Hospital" includes mental health treatment center for inpatient and outpatient care of a mental or nervous disorder or chemical dependency treatment center for inpatient and outpatient care of substance abuse.

Physician is changed to include the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in the certificate, and when benefits would be payable if the services were provided by a doctor or medicine (M.D.) or doctor of osteopathy (D.O.):

- A licensed professional counselor
- A certified chemical dependency counselor
- A certified physician assistant
- A certified naturopathic physician

FOR INSURED PERSONS RESIDING IN NEW HAMPSHIRE

The following benefits are added to the YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED, subject to the Deductibles and Co-Payments shown in the certificate:

Enteral Formulas. Non-prescription enteral formulas upon written order of a physician for:

1. Treatment of impaired absorption of nutrients caused by disorders of the gastrointestinal tract.
2. Treatment of an insured person with an inherited disease of amino acids and organic acids. This also includes food products modified to be low protein.
The benefit for **Prosthetic Devices** includes scalp hair prostheses when required as a result of hair loss due to alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia, or permanent hair loss due to injury.

The benefit for **Mental or Nervous Disorders or Substance Abuse** will include *physician* visits for applied behavioral analysis, when provided by a person professionally certified by the national Behavior Analyst Certification Board or performed under the supervision of a person professionally certified by the national Behavior Analyst Certification Board.

The benefit for **Hearing Aid Services** is amended to include coverage for professional services associated with the practice of fitting, dispensing, servicing, or sale of hearing instruments or hearing aids and the cost of a hearing aid for each ear, as needed, as well as related services necessary to assess, select and fit the hearing aid.

The benefit for **Organ and Tissue Transplants** is amended to include coverage for laboratory fee expenses up to $150 for bone marrow donor testing, for utilization in bone marrow transplantation.

The following changes are made with respect to **Cancer Clinical Trials**:

1. Wherever the term "cancer clinical trials" appears in the certificate booklet, it is changed to "clinical trials".

2. The **Cancer Clinical Trials** provision under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is deleted and replaced by the following:

   **Clinical Trials.** Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV clinical trials for cancer or any other life-threatening condition if the all of the following conditions are met:

   1. The treatment provided in a clinical trial must be approved by:
      a. One of the National Institutes of Health (NIH);
      b. An NIH cooperative group or an NIH center;
      c. The FDA in the form of an investigational new drug application or exemption;
d. The federal department of Veterans Affairs or Defense; or

e. An institutional review board of an institution in New Hampshire that has a multiple assurance contract approved by the Office of Protection from Research Risks of the NIH;

2. The standard treatment has been or would be ineffective, does not exist, or there is no superior noninvestigational treatment alternative; and

3. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.

Routine patient care costs means the cost of any medically necessary health care service that is incurred as a result of the treatment being provided which would otherwise be covered under the plan, including:

1. Drugs and devices provided during the clinical trial which are not the subject of the clinical trial, provided those drugs or devices have been approved for sale by the FDA; and

2. The reasonable and medically necessary services to administer the drug or use the device under evaluation in the clinical trial.

Routine patient care costs does not include any of the items listed below. You will be responsible for the costs associated with any of the following, in addition to the costs of non-covered services.

1. The cost of drugs or devices not approved by the FDA for any indication.

2. The cost of any non-health care services that you may be required to receive as a result of the treatment provided for the purposes of the clinical trial.

3. The cost of managing the research associated with the clinical trial.

4. The non-covered costs under the plan.

The term “insured employee” in the “Eligible Status” provision under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS is changed to include permanent part time employees who work at least 15 hours a week in the conduct of the business of the group, and whose
regular place of employment and usual residence is not in the State of California.

The definition of “Day Treatment Center” in the DEFINITIONS section includes a community mental health center.

The following is added to the definition of “Hospital” in the DEFINITIONS section:

The term “hospital” includes a public or licensed mental hospital or an approved psychiatric residential program.

The definition of “Physician” in the DEFINITIONS section is changed to include the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in the certificate, and when benefits would be payable if the services were provided by a doctor or medicine (M.D.) or doctor of osteopathy (D.O.):

- A licensed pastoral counselor
- A licensed clinical mental health counselor
- A certified behavior analyst

Under the CONTINUATION OF COVERAGE, the continuation coverage will not end at the end of 36 months from the Qualifying Event for a surviving spouse, divorced or separated spouse who is 55 years of age or older on the date of the Qualifying Event, but will end on the earliest of:

1. The date the policy terminates;
2. The end of the period for which premiums are last paid;*
3. The date such spouse becomes covered under any other group health plan; or
4. The date such spouse becomes entitled to Medicare.

To elect this continuation, you must notify the employer in writing within 30 days of the decree of divorce or separation.

The continuation is subject to payment of premiums to the employer at the time the group premium is due. The group may require that you pay the entire cost of your continuation coverage. The group is responsible to us for the timely payment of premium due for the continuation of your coverage under this policy.
The rate for this continuation coverage will be 102% of the applicable group rate.

*If continuation coverage of a former dependent spouse would end because premium payments were not received within 30 days of the premium due date, such coverage will not end prior to the employer giving 30 days notice to the former spouse, during which time the former spouse will be given the opportunity to make the premium payments due or secure such payment from the employee.

The following **STATE CONTINUATION FOR QUALIFYING INSURED PERSONS** is added to your certificate:

**STATE CONTINUATION FOR QUALIFYING INSURED PERSONS**

Subject to payment of premium as stated in the policy, coverage under this plan may be continued for you, a surviving spouse or dependent in accordance with the following provisions if this policy is terminated for any reason.

**Notice and Election.** We will notify the insured employee, surviving spouse or dependent of the right to continue coverage within 15 days after the termination of this policy.

The insured person must provide us with written notice of election along with the first monthly premium within 31 days from the date notice of the option to elect continuation of coverage was sent by us.

**Cost of Coverage.** The cost of your continuation coverage will be 102% of the applicable group rate. You must pay this cost directly to us.

**When Continuation Ends.** This continuation will end on the earliest of:

1. The end of the period for which premiums were last paid;
2. The end of 39 weeks from the date of termination of the policy;
3. The date continuation would have ended under the Continuation of Coverage provisions if the policy was not terminated;
4. The date the insured person becomes eligible for coverage under an employer group health plan.
If your continuation under this plan ends in accordance with items 2 or 3 above, you are eligible for medical conversion coverage.

FOR INSURED PERSONS RESIDING IN NEW JERSEY

Item 3, b under the Definition of Family Member under the ELIGIBLE STATUS in the HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS section is deleted and replaced by the following:

b. The unmarried child is under 26 years of age, or if age 26 or over, that child is eligible until his or her 31st birthday, provided: (i) he or she has no dependent of his or her own, (ii) is a resident of New Jersey or enrolled as a full-time student (for 12 or more units or credits) in a properly accredited secondary or post-secondary educational or vocational institution (a college, university, or trade or technical school). Any break in the school calendar will not disqualify a child from coverage under this provision. An unmarried child less than 31 years of age who enters or returns to an eligible status will become eligible for coverage on the first day of the month following the date an enrollment application is filed on their behalf.

FOR INSURED PERSONS RESIDING IN NEW MEXICO

The following maximum is added to the MEDICAL BENEFIT MAXIMUMS under SUMMARY OF BENEFITS: MEDICAL BENEFITS:

Early Intervention Services

- For covered early intervention services...............................$3,500 per calendar year

The Dental Care provision under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is deleted and replaced by the following:
Dental Care

1. **Admissions for Dental Care.** Listed inpatient hospital services for up to three days during a hospital stay, when such stay is required for dental treatment and has been ordered by a physician (M.D.) and a dentist (D.D.S. or D.M.D.). We will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. Hospital stays for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.

2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a hospital or ambulatory surgical center. This applies only if (a) the insured person has a physical or mental condition for which dental treatment under local anesthesia may not be successful, or (b) the insured person’s health is compromised and general anesthesia is medically necessary, or (c) the insured child is extremely uncooperative, fearful, anxious or cannot communicate and has such severe dental problems that if left untreated may result in pain, infection, loss of teeth or other increased oral or dental morbidity, or (d) the insured person has extensive oral, facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised, or (e) other procedures for which hospitalization or general anesthesia is medically necessary. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

3. **Dental Injury.** Services of a physician (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an accidental injury to natural teeth. Coverage shall be limited to only such services that are medically necessary to repair the damage done by the accidental injury and/or restore function lost as a direct result of the accidental injury. Damage to natural teeth due to chewing or biting is not accidental injury.

The following provision is added to YOUR MEDICAL BENEFITS:

**MEDICAL CARE THAT IS COVERED:**

**Early Intervention Services.** In addition to any other benefits provided under the plan, medically necessary early intervention services for a dependent child from birth through three years of age, subject to the following:
4. The services are provided by the Family, Infant, Toddler (FIT) program administered by the New Mexico Department of Health.

5. The services are provided as part of an individualized family service plan and delivered by certified and licensed personnel working in early intervention programs approved by the Department of Health.

The **Cancer Clinical Trials** provision under **YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED** is deleted and replaced by the following:

**Cancer Clinical Trials.** Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III or phase IV cancer clinical trials if all of the following conditions are met:

1. The clinical trial is being carried out for purposes of the prevention, early detection or treatment of cancer for which standard cancer treatment has not been effective.

2. The clinical trial is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent.

3. The clinical trial is being provided in the state of New Mexico as part of a scientific study of a new therapy or intervention that is being conducted at an institution in the state and is for the treatment, palliation or prevention of cancer in humans.

4. The clinical trial is being provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial approved by at least one of the following:
   
   a. One of the National Institutes of Health,
   b. A National Institutes of Health cooperative group or center,
   c. The United States Department of Defense,
   d. The federal Food and Drug Administration,
   e. The United States Department of Veterans Affairs, or
   f. A qualified research entity that meets the criteria established by the federal National Institutes of Health for grant eligibility.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services
which would otherwise be covered under the plan, including health care services which are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs does not include any of the items listed below. You will be responsible for the costs associated with any of the following, in addition to the costs of non-covered services.

1. Drugs or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the plan.
5. Health care services customarily provided by the research sponsors free of charge to insured persons enrolled in the trial.

For payment for non-participating providers, the cost will be based on the lesser of the billed charge or the amount that ordinarily applies when services are provided by a participating provider.

The following Tobacco Cessation provision is added to YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED:

**Tobacco Cessation.** Covered services shown below for tobacco cessation:
1. Diagnostic services necessary to identify tobacco use, use-related conditions and dependence.

2. Cessation counseling for up to 90 minutes total provider contact time per calendar year or two multi-session group programs per calendar year.

If you begin a course of cessation counseling, it will count as an entire course of treatment even if you stop or fail to complete the course.

The **Special Food Products** provision under **YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED** is deleted and replaced by the following:

**Inborn Errors of Metabolism.** All medical benefits when provided for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism, for which medically standard methods of diagnosis, treatment and monitoring exist.

Benefits include expenses for diagnosing, monitoring and controlling the disorder by nutritional and medical assessment, including but not limited to, clinical services, biochemical analysis, medical supplies, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used to make up for the metabolic abnormality and to maintain adequate nutritional status.

“Medical foods” means nutritional substances in any form that are:

1. Formulated to be consumed or given enterally under supervision of a physician;
2. Specifically processed or formulated to be distinct in one or more nutrients present in natural food;
3. Intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient needs as determined by medical evaluation; and
4. Needed to improve growth, health and metabolic homeostasis.

Most medical foods are obtained from a pharmacy and are covered under your plan’s prescription drug benefits (see **YOUR PRESCRIPTION DRUG BENEFITS**). Medical foods that are not available from a pharmacy.
pharmacy are covered as medical supplies under your plan’s medical benefits.

The definition of “Creditable Coverage” in the DEFINITIONS section is deleted and replaced by the following:

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers’ compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to reduce the length of the pre-existing condition exclusion period under this plan and/or to set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition.

If your prior coverage was through an employer, you will receive credit for that coverage if it ended because your employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer’s contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date you become eligible under this plan is no more than 180 days (not including any waiting period imposed under this plan).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this plan is no more than 95 days (not including any waiting period imposed under this plan).

The definition of “Physician” in the DEFINITIONS section is deleted and replaced by the following:
Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. A person who: (a) is practicing within the scope of his or her license or certification as a practitioner of the healing arts; (b) is providing a service for which benefits are specified in this booklet, when benefits would be payable if the services are provided by a physician as defined above.

FOR INSURED PERSONS RESIDING IN NORTH CAROLINA

NOTICE: Your actual expenses for covered services may exceed the stated co-payment amount because actual provider charges may not be used to determine plan and insured payment obligations.

Wherever the term “cancer clinical trials” appears in the certificate booklet, it is changed to “covered clinical trials”.

The Cancer Clinical Trials provision under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is deleted and replaced by the following:

Covered Clinical Trials. Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV clinical trials if all of the following conditions are met:

1. The treatment provided in a clinical trial must either:
   a. Involve a drug that is exempt under federal regulations from a new drug application, or
   b. Be approved by (i) one of the National Institutes of Health, (ii) centers or cooperative groups that are funded by the National Institutes of Health, (iii) the federal Food and Drug Administration in the form of an investigational new drug application, (iv) the Centers for Disease Control, (v) the Agency for Health Care Research and Quality, (vi) the United
2. The treatment must involve a life-threatening medical condition.

3. Participation in such clinical trials must be recommended by your physician after determining participation has a meaningful potential to benefit the insured person.

4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the plan, including health care services which are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs does not include any of the items listed below. You will be responsible for the costs associated with any of the following, in addition to the costs of non-covered services.

1. Drugs or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the plan.

5. Health care services customarily provided by the research sponsors free of charge to insured persons enrolled in the trial.

The definition of "Physician" in the DEFINITIONS section is changed to include a certified fee-based practicing pastoral counselor, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in the certificate, and when benefits would be payable if the services were provided by a doctor or medicine (M.D.) or doctor of osteopathy (D.O.).

FOR INSURED PERSONS RESIDING IN OHIO

The definition of "Physician" in the DEFINITIONS section is changed to include a registered mechanotherapist who has completed educational requirements on or before November 3, 1975, in the list of providers recognized when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in the certificate, and when benefits would be payable if the services were provided by a doctor of medicine (M.D.) or doctor of osteopathy (D.O.).

FOR INSURED PERSONS RESIDING IN OKLAHOMA

The following changes are made to the DEFINITIONS section:

1. The definition of “Emergency” is deleted and replaced by the following:

   Emergency is the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient’s health in serious jeopardy; (2) serious impairment of bodily functions; or (3) serious dysfunction of any bodily organ or part. We will have sole and final determination as to whether services were rendered in connection with an emergency.
2. The definition of “Physician” is deleted and replaced by the following:

**Physician** means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. A person who: (a) is practicing within the scope of his or her license or certification as a practitioner of the healing arts; (b) is providing a service for which benefits are specified in this booklet, when benefits would be payable if the services are provided by a physician as defined above.

However, services of a physical therapist, an occupational therapist or a respiratory care practitioner are covered only by referral of a physician as defined in 1 above.

**FOR INSURED PERSONS RESIDING IN PENNSYLVANIA**

The following benefit is added to the *plan*, subject to the same Co-Payment, Out-of-Pocket and Medical Benefit Maximums applicable to other medical services and supplies provided under the *plan*, but the Calendar Year Deductible will not apply to this benefit:

**Nutritional Supplements.** *Medically necessary* nutritional supplements for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria administered under the direction of a physician.

The exclusion of food supplements under *YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED* will not apply to nutritional supplements as provided above.

**FOR INSURED PERSONS RESIDING IN SOUTH CAROLINA**

The following is added to the “OUT-OF-POCKET AMOUNTS” provision under *YOUR MEDICAL BENEFITS: DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS:*
Prior Plan Out-of-Pocket Amounts. If you were covered under the prior plan any amount applied toward your out-of-pocket amount under the prior plan during the 90 days preceding the effective date of this plan, will be applied toward your Out-of-Pocket Amount under this plan; provided that, such amounts were for charges that would be covered under this plan.

FOR INSURED PERSONS RESIDING IN SOUTH DAKOTA

The definition of “Child” in the Definition of Family Member under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS, is deleted and replaced by the following:

3. Child is the employee’s, spouse’s or domestic partner’s natural child, stepchild, legally adopted child, or a child for whom the employee, spouse, or domestic partner has been appointed legal guardian by a court of law, subject to the following:

a. The child is under 26 years of age.

b. If the unmarried child is age 26 or over, that child is eligible until his or her 29th birthday, provided he or she is enrolled as a full-time student (for 12 or more units or credits) in a properly accredited secondary or post-secondary educational or vocational institution (a college, university, or trade or technical school). Any break in the school calendar will not disqualify a child from coverage under this provision. A child 26 years of age, but, less than 29 years of age who enters or returns to an eligible status will become eligible for coverage on the first day of the month following the date an enrollment application is filed on their behalf.

c. The unmarried child is 26 years of age, or more and: (i) was covered under the prior plan, or has six or more months of creditable coverage, (ii) is chiefly dependent on the employee, spouse or domestic partner for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A physician must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 31-days of the date the child first becomes eligible under this plan. After a period of two years has passed from the initial certification to us, we may request proof of continuing dependency and that a physical or mental condition
still exists, but, not more often than once each year. This exception will last until the child is no longer chiefly dependent on the employee, spouse or domestic partner for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

d. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the employee, spouse or domestic partner have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child’s adoption.

Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child’s birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the employee, the spouse’s or domestic partner’s right to control the health care of the child.

e. A child for whom the employee, spouse or domestic partner is a legal guardian is considered eligible on the date of the court decree (the “eligibility date”). We must receive legal evidence of the decree.
FOR INSURED PERSONS RESIDING IN TEXAS

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS’ COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS’ COMPENSATION SYSTEM.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Anthem Blue Cross Life and Health’s toll-free telephone number provided on your ID card for information or to make a complaint regarding claims matters.

You may also write to Anthem Blue Cross Life and Health at:

Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, CA 91367

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance:
P.O. Box 149104
Austin, TX 78714-9104

FAX # (512) 475-1771

AVISOS IMPORTANTES

Para obtener información o para someter una queja:

Usted puede llamar al número de teléfono gratis de Anthem Blue Cross Life and Health que se le provee en su tarjeta de identificación para información o para someter una queja sobre situaciones de reclamación.

Usted también puede escribir a Anthem Blue Cross Life and Health:

Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, CA 91367

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:
P.O. Box 149104
Austin, TX 78714-9104

FAX # (512) 475-1771
PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact Anthem Blue Cross Life and Health first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con Anthem Blue Cross Life and Health primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

The Diabetes provision under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is deleted and replaced by the following:

**Diabetes Equipment and Supplies.** Equipment and supplies provided for the treatment of diabetes, including:

1. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.

2. Insulin pumps, both external and implantable, and associated appurtenances, including:
   a. Insulin infusion devices;
   b. Batteries;
   c. Skin preparation items;
   d. Adhesive supplies;
   e. Infusion sets;
f. Insulin cartridges;

g. Durable and disposable devices to assist in the injection of insulin; and

h. Other required disposable supplies.

Repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer’s warranty or purchase agreement and rental fees for pumps during the repair and necessary maintenance of insulin pumps are covered, but not in excess of the purchase price of a similar replacement pump.


4. Podiatric appliances, including up to two pairs of therapeutic footwear per year, devices for the prevention of complications associated with diabetes.

Items 1 through 3 above are covered under your plan’s benefits for durable medical equipment (see “Durable Medical Equipment”). Item 4 above is covered under your plan’s benefits for prosthetic devices (see “Prosthetic Devices”).

5. The following items are covered under your prescription drug benefits:

   a. Test strips for blood glucose monitors;
   b. Visual reading and urine test strips;
   c. Lancets and lancet devices;
   d. Insulin and insulin analog preparations;
   e. Injection aids, including devices used to assist with insulin injections and needleless systems;
   f. Syringes;
   g. Prescriptive and non-prescriptive medications for controlling blood sugar levels;
   h. Glucagon emergency kits.

   These items must be obtained either from a retail pharmacy or through the mail service program (see YOUR PRESCRIPTION DRUG BENEFITS).

On approval of the United States Food and Drug Administration and if medically necessary, this plan will include coverage of new or
improved diabetes equipment or diabetes supplies, including improved insulin or other prescription drugs.

**Diabetes Self-Management Training.** On the written order of a physician, diabetes self-management training services provided to an insured person or his or her caretaker:

1. When there is initial diagnosis of diabetes;
2. When there is a significant change in the symptoms or condition of the insured person that requires changes in the insured person self-management regime; or
3. When periodic or episodic continuing education is needed because of the development of new techniques and treatment for diabetes.

The diabetes self-management training services must be provided by the following:

1. A diabetes self-management training program that is recognized by the American Diabetes Association; or
2. A team coordinated by a Certified Diabetes Educator (CDE) that includes at least a dietitian and a nurse educator. Other team members may be a pharmacist and a social worker. Other than a social worker, all team members must have recent experience in teaching diabetes self-management; or
3. A Certified Diabetes Educator; or
4. A licensed health care professional, including a physician, a physician assistant, a registered nurse, a licensed or registered dietitian, or a pharmacist, who has been determined by his or her licensing board to have recent experience in teaching diabetes self-management.

Diabetes self-management training includes the development of an individualized management plan that is created for and in collaboration with the insured person.

The following provisions are added to **YOUR MEDICAL BENEFITS:**

**MEDICAL CARE THAT IS COVERED:**

**Acquired Brain Injury.** Services and supplies provided in connection an acquired brain injury:

1. Cognitive rehabilitation therapy;
2. Cognitive communication therapy;
3. Neurocognitive therapy and rehabilitation;
4. Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment;
5. Neurofeedback therapy; and
6. Remediation, post-acute transition services, or community reintegration services, including outpatient day treatment services or other post-acute care treatment services necessary as a result of and related to an acquired brain injury.

Services under this benefit include appropriate post-acute treatment, including coverage for periodic reevaluation of an insured person who:

1. has incurred an acquired brain injury;
2. has been unresponsive to treatment; and
3. becomes responsive to treatment at a later date.

Coverage under this benefit is provided if treatment is provided in a hospital or other facility, including an assisted living facility. This coverage is provided according to the terms and conditions of this plan that apply to all other medical conditions.

**Telemedicine.** Diagnosis, consultation, treatment, transfer of medical data and medical education through the use of electronic media such as interactive audio, video or other electronic media. This does not include services performed using a telephone or facsimile machine.

The **Outpatient Speech Therapy** provision in **YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED** is deleted and replaced by the following:

**Hearing and Speech.** The services of a **physician** for care and treatment of loss or impairment of hearing or speech.
The definition of “Child” in the Definition of Family Member under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS, is deleted and replaced by the following:

3. **Child** is the employee’s, spouse’s or domestic partner’s natural child, stepchild, legally adopted child, grandchild, or a child for whom the employee, spouse, or domestic partner has been appointed legal guardian by a court of law, subject to the following:

   a. The child is under 26 years of age.

   b. The unmarried child is 25 years of age, or more and: (i) was covered under the prior plan, was covered as a family member of the employee under another plan or health insurer, or has six months of other creditable coverage, (ii) is chiefly dependent on the employee, spouse or domestic partner for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A physician must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 31-days of the date the child first becomes eligible under this plan. After a period of two years has passed from the initial certification to us, we may request proof of continuing dependency and that a physical or mental condition still exists, but, not more often than once each year. This exception will last until the child is no longer chiefly dependent on the employee, spouse or domestic partner for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

   c. The grandchild is younger than 25 years of age and is a dependent of the employee, spouse or domestic partner for federal income tax purposes at the time application for coverage is made. Coverage may not be terminated solely because the covered grandchild is no longer a dependent of the employee, spouse or domestic partner for federal income tax purposes.

   d. The employee, spouse or domestic partner is legally required to provide group health coverage for the child pursuant to an administrative or court order. If not already enrolled, the employee, spouse or domestic partner must enroll in order for the child to be eligible for permanent coverage.
e. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence that the employee, spouse or domestic partner either: (i) is a party in a suit in which the adoption of the child by the employee, spouse or domestic partner is sought; or (ii) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child’s adoption.

f. A child for whom the employee, spouse or domestic partner is a legal guardian is considered eligible on the date the court decree (the “eligibility date”). We must receive legal evidence of the decree.

Item 6 under HOW COVERAGE ENDS in the section entitled “HOW COVERAGE BEGINS AND ENDS” is deleted and replaced by the following:

6. If you no longer meet the requirements set forth in the “Eligible Status” provision of HOW COVERAGE BEGINS, your coverage ends as of the premium due date coinciding with or following the date you cease to meet such requirements, however:

   a. coverage will remain in force until the end of the calendar month in which the group notifies us that you are no longer eligible; and

   b. the group will be liable to us for any premium, including premium for any family member’s coverage, for the period of coverage until the end of the calendar month in which the group gives us such notice.

The following STATE CONTINUATION OF COVERAGE section is added to the certificate:

STATE CONTINUATION OF COVERAGE

If your coverage terminates, you will have the right to continuation under the policy as outlined below. In order to be eligible for this option:

1. You must have been continuously covered under the policy for at least three consecutive months prior to termination; and
2. Coverage terminated for any reason other than involuntary termination for cause, including termination of coverage for the class of employees to which you belong.

Written application and payment of the first premium must be made within 31 days following the later of:

1. The date the group coverage would otherwise terminate; or
2. The date the insured person is given notice of the right of continuation by the group.

Cost of Coverage. The group may require that you pay the entire cost of your continuation coverage. The group is responsible to us for the timely payment of the premiums due for the continuation of any insured person's coverage under this policy. The premium rate will be 102% of the group premium. The premium will be payable in advance to the group on a monthly basis.

When Continuation Ends. This continuation will end on the earliest of:

1. The end of six months from the date the insured person elected this continuation;
2. The end of the period for which premiums are last paid;
3. The date the policy terminates;
4. The date the insured person is covered or could be covered under Medicare;
5. The date the insured person becomes covered for similar benefits under another group or individual health policy;
6. The date the insured person becomes eligible for similar benefits under another group plan; or
7. The date on which similar benefits are provided for or available to the insured person under any state or federal law.

Texas Health Insurance Risk Pool

Not less than 30 days before the end of the six months after the date the insured employee or insured family member elects continuation of the policy, the insurer shall notify the insured employee or insured family member that he/she may be eligible under the Texas Health Insurance Risk Pool as provided under Article 3.77 of the Texas
Insurance Code, and the insurer shall provide the address of applying to such pool to the insured employee or insured family member.

The following definitions are added to the DEFINITIONS section:

1. The definition of “Emergency” is deleted and replaced by the following:

   **Emergency** is a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient’s health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

2. The definition of “Physician” is changed to include the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in the certificate, and when benefits would be payable if the services were provided by a doctor of medicine (M.D.) or doctor of osteopathy (D.O.):
   - A licensed dietitian
   - A licensed professional counselor
   - A licensed psychological associate
   - A nurse first assistant

**FOR INSURED PERSONS RESIDING IN VERMONT**

This amendment applies to your certificate only if 26 or more of the employees of the group reside in Vermont.

The following provision is added to YOUR MEDICAL BENEFITS:

**MEDICAL CARE THAT IS COVERED:**

**Tobacco Cessation.** Tobacco cessation medication, if prescribed by a physician, including over-the-counter medication. We will cover up to one three-month supply per year, subject to the plan’s applicable prescription drug co-payment.

The benefit for **Mental or Nervous Disorders or Substance Abuse** will include applied behavioral analysis for children age 18 months to six
years old when provided by a person professionally certified by the national Behavior Analyst Certification Board or performed under the supervision of a person professionally certified by the national Behavior Analyst Certification Board.

FOR INSURED PERSONS RESIDING IN VIRGINIA

The “Work-Related” exclusion under MEDICAL CARE THAT IS NOT COVERED in the YOUR MEDICAL BENEFITS section is deleted and replaced by the following:

**Work-Related.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.

If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers’ compensation, benefits will be provided subject to our right of recovery or reimbursement under the Virginia Insurance Code Section 38.2-3405.

The section entitled REIMBURSEMENT FOR ACTS OF THIRD PARTIES is deleted and of no further effect.

FOR INSURED PERSONS RESIDING IN WASHINGTON

The definition of “Physician” in the DEFINITIONS section is deleted and replaced by the following:

**Physician** means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. A person who: (a) is practicing within the scope of his or her license or certification as a practitioner of the healing arts; (b) is providing a service for which benefits are specified in this booklet, when benefits would be payable if the services are provided by a physician as defined above.
FOR INSURED PERSONS RESIDING IN WISCONSIN

This amendment applies to your certificate only if more than 25% of the employees of the group reside in Wisconsin.

The following provision is added to YOUR MEDICAL BENEFITS:

MEDICAL CARE THAT IS COVERED:

**Autism Spectrum Disorders.** Intensive-level services and nonintensive-level services in the treatment of a primary verified diagnosis of autism disorder, Asperger’s syndrome, and pervasive developmental disorder not otherwise specified. Both intensive and nonintensive level services must be evidence-based and must be prescribed by a doctor of medicine (M.D.) or doctor of osteopathy (D.O.). Services must be provided by any of the following who are qualified to provide intensive-level or nonintensive-level services:

- A psychiatrist
- A psychologist
- A social worker certified or licensed to practice psychotherapy
- A professional working under the supervision of an outpatient mental health clinic
- An occupational therapist
- A speech therapist
- A behavior analyst who is licensed under section 440.312 of Wisconsin state law
- A paraprofessional working under the supervision of a psychiatrist, psychologist, or social worker.

Intensive-level services are evidence-based behavioral health therapy designed to help an individual with autism spectrum disorder overcome the cognitive, social, and behavioral deficits associated with that disorder. Treatment must be commenced after the individual is two years of age and before the individual is nine years of age. Up to 48 months of intensive-level services will be provided. Any previous services received by an insured person, regardless of payor, will be credited against this 48 month period.

Nonintensive-level services are evidence-based therapy that occurs after the completion of treatment with intensive-level services and that is designed to sustain and maximize gains made during treatment with intensive-level services or, for an individual who has
not and will not receive intensive-level services, evidence-based therapy that will improve the individual’s condition.

The following changes are made under the **HOW COVERAGE BEGINS AND ENDS** section:

1. The definition of “Child” in the **Definition of Family Member** under **HOW COVERAGE BEGINS AND ENDS**: **HOW COVERAGE BEGINS**, is deleted and replaced by the following:

3. **Child** is the *employee’s, spouse’s or domestic partner’s* unmarried natural child, stepchild, legally adopted child, or a child for whom the *employee, spouse or domestic partner* has been appointed legal guardian by a court of law, subject to the following:

   a. The child is under 26 years of age.

   b. The child is a full-time student 26 years of age or older, that was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces before turning 27 years of age, and while attending, on a full-time basis, an institution of higher education. These children may maintain dependent coverage for as long as they maintain full-time student status at an institution of higher education. When the adult child is called to active duty more than once within a four-year period of time, the child’s age at the time of the first call to active duty will determine eligibility.

   c. The unmarried child is 26 years of age, or older and: (i) was covered as a *family member* of the *employee* under another plan or health insurer, or has six or more months of other *creditable coverage*, (ii) is chiefly dependent on the *employee, spouse or domestic partner* for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 31-days of the date the child first becomes eligible under this plan. After a period of two years has passed from the initial certification to us, we may request proof of continuing dependency and that a physical or mental condition still exists, but, not more often than once each year. This exception will last until the child is no longer chiefly dependent on the *employee, spouse or domestic partner* for
support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

d. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the employee, spouse or domestic partner have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child’s adoption.

Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child’s birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the employee’s, spouse’s or domestic partner’s right to control the health care of the child.

e. A child for whom the employee, spouse or domestic partner is a legal guardian is considered eligible on the date of the court decree (the “eligibility date”). We must receive legal evidence of the decree.

The definition of “Physician” in the DEFINITIONS section is changed to include the following providers, but only for the treatment of autism spectrum disorder as specified in this amendment to the certificate:

- A behavior analyst who is licensed under section 440.312 of Wisconsin state law
- A paraprofessional working under the supervision of a psychiatrist, psychologist, or social worker.

FOR INSURED PERSONS RESIDING IN WYOMING

The Cancer Clinical Trials provision under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED is deleted and replaced by the following:

Cancer Clinical Trials. Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase
I, phase II, phase III and phase IV study or clinical trials for the treatment of cancer if all of the following conditions are met:

1. The treatment provided in a clinical trial must be approved by (i) one of the National Institutes of Health or a research entity that meets the NIH granting criteria, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.

2. The medical treatment is provided by a licensed health care provider and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner.

3. Before starting your participation in the clinical trial or study, you have signed a statement of consent indicating that you have been informed of (i) the procedure to be undertaken; (ii) alternative methods of treatment; and (iii) the general nature and extent of risks associated with participation in the clinical trial or study.

4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the plan, including health care services which are:

1. Typically provided absent a clinical trial.

2. A drug provided to a patient during a cancer clinical trial, other than the drug that is the subject of the clinical trial, if the drug has been approved by the federal Food and Drug Administration for use in treating the patient’s particular condition.

Routine patient care costs do not include the costs associated with any of the following:

1. Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.

2. Coverage for any drug or device that is paid for by the manufacturer, distributor or provider of the drug or device.

3. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may
require as a result of the treatment provided for the purposes of the clinical trial.

4. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.

5. Health care services customarily provided by the research sponsors free of charge to insured persons enrolled in the trial.

6. Any costs for the management of research relating to the clinical trial or study.

**Note:** You will be financially responsible for the costs associated with non-covered services.

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE.