



AMENDMENT

issued by

**ANTHEM BLUE CROSS LIFE AND HEALTH
INSURANCE COMPANY**

to

VENTURA COUNTY COMMUNITY COLLEGE DISTRICT

FACULTY

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, 2014.

FOR INSURED PERSONS RESIDING IN ARKANSAS

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.

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

Human Papilloma Virus (HPV) Vaccine. Services and supplies provided in connection with the administration of the HPV vaccine as standard medical practice. The cost of the vaccination will not be subject to any *calendar year deductibles* or co-payments under this *plan*, but all other services and supplies will be subject to all of the applicable terms and conditions of this *plan*.

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 Calendar Year Deductible will not apply to colonoscopy or sigmoidoscopy procedures initially undertaken as screening procedures, nor to procedures conducted at a time, or during an appointment which was initially intended to provide colorectal cancer screening, such as removal of a polyp. In addition, the Calendar Year Deductible will not apply to any additional colonoscopy ordered in the same year by a *physician* for an *insured person*.

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. There will be no Co-Payment for additional colonoscopies ordered by a *physician* in the same year as a screening colonoscopy or sigmoidoscopy.
3. The Co-Payment for Testing for Bone Marrow Transplants shall not exceed 20% of the cost for such testing.
4. The following Co-Payment maximums will apply to Diagnostic Services provided by a *participating provider*:
 - 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 following provisions are added to **YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED**:

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*:

- Examinations.
- Diagnostic tests and work-ups.
- Medications administered in a *physician's* office.
- Reconstructive surgery, except for sterilization reversal.
- Supplies and appliances.

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

- In vitro fertilization (IVF) up to 2 cycles, with not more than 2 embryo implantations per cycle, per the *insured person's* lifetime,
- Zygote intra-fallopian transfer (ZIFT) up to 2 cycles, with not more than 2 embryo implantations per cycle, per the *insured person's* lifetime,
- Gamete intra-fallopian transfer (GIFT) up to 2 cycles, with not more than 2 embryo implantations per cycle, per the *insured person's* lifetime,
- Cryopreserved embryo transfers,
- Intracytoplasmic sperm injection (ICSI),
- Ovulation induction up to 4 cycles per the *insured person's* lifetime,

- Intrauterine insemination up to 3 cycles per the *insured person's* lifetime, and
- 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.

8. **Pain Management.** Pain treatment ordered by a pain management specialist, including all medically necessary means to make a diagnosis and develop a treatment plan, including the use of necessary medications and procedures.

A pain management specialist is a physician who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, physiatrist, neurologist, oncologist or radiation oncologist with additional training in pain management.

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 “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.

2. 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

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.

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 **REIMBURSEMENT FOR ACTS OF THIRD PARTIES** provision is 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

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 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.

4. 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 group *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 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 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 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 as recognized by the American Society for Reproductive Medicine (ASRM), the American College of Obstetrics and Gynecology (ACOG), the Society of Assisted Reproductive Technology (SART), or another infertility expert recognized by the state insurance commissioner.
2. The *insured person* is unable to conceive or produce conception during a period of one year if the female is age 35 or younger, or during a period of six months if the female is over the age of 35. For purposes of meeting the criteria of infertility, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one year or six month period, as applicable.
3. Covered services include, but are not limited to, the following:
 - Artificial insemination (AI) and intrauterine insemination (IUI).
 - In vitro fertilization and embryo transfer (IVF-ET).
 - Gamete intrafallopian transfer (GIFT).
 - Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any.
 - Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility.
 - Zygote Intrafallopian Transfer (ZIFT).
 - Assisted Hatching.
 - Cryopreservation of eggs.

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 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.

With respect to the **Well Baby and Well Child Care** benefit provided under the *plan*, the covered services provided under this benefit will not be subject to any deductibles, co-payments or benefit maximums.

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 *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, congenital conditions, and other health conditions provided through a program established by law or regulation.
3. Certain services are covered under the "Preventive Care Services" benefit. Please see that provision for further details.

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 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 homeostatis.

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, the definition of hospital also includes: (1) *psychiatric health facilities* (only for the acute phase of a *mental or nervous disorder* or substance abuse), and (2) *residential treatment centers*. "Hospital" also includes a 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 and such license is required to render that service, and is providing a service for which benefits are specified in this booklet:

A certified chemical dependency counselor

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 **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 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 and such license is required to render that service, and is providing a service for which benefits are specified in this booklet:

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*.
4. **Cleft Palate.** *Medically necessary* dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.
5. **Orthognathic surgery.** Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is *medically necessary* to attain functional capacity of the affected part.

Important: If you decide to receive dental services that are not covered under this *plan*, a *participating provider* who is a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this *plan*, please call us at the customer service telephone number listed on your ID card. To fully understand your coverage under this *plan*, please carefully review this Certificate of Insurance document.

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 following provision is added to **YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED:**

Human Papilloma Virus (HPV) Vaccine. Services and supplies provided in connection with the administration of the HPV vaccine as standard medical practice. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

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* 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 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) licensed or certified to practice where the care is provided and is practicing within the scope of his or her license or certification as a practitioner of the healing arts; (b) is rendering a service within the scope of that license and such license is required to render that service; and (c) is providing a service for which benefits are specified in this booklet.

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.

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 and such license is required to render that service, and is providing a service for which benefits are specified in this booklet.

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 and such license is required to render that service, and is providing a service for which benefits are specified in this booklet

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 is licensed or certified to practice where the care is provided, is rendering a service within the scope of that license or certification and such license or certification is required to render that service, and is providing a service for which benefits are specified in this booklet.

However, the services of a licensed professional clinical counselor, a physical therapist, a speech pathologist, an audiologist, an occupational therapist, a respiratory care practitioner, a *psychiatric mental health nurse*, and a registered dietitian 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

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Anthem Blue Cross Life and Health que se le provee en su tarjeta de

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

Web: <http://www.tdi.state.tx.us>

E-mail:

ConsumerProtection@tdi.state.tx.us

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.

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

Web: <http://www.tdi.state.tx.us>

E-mail:

ConsumerProtection@tdi.state.tx.us

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).

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

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.

3. Biohazard disposal containers.
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.

Colorectal Cancer Screening. Services and supplies provided in connection with examinations and laboratory tests in accordance with a medically recognized screening examination for the detection of colorectal cancer for any nonsymptomatic covered person who is at least 50 years old, including:

1. A fecal occult blood test performed annually; and a flexible sigmoidoscopy performed every five years; or
2. A colonoscopy performed every 10 years.

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 and such license is required to render that service, and is providing a service for which benefits are specified in this booklet:

- A licensed dietitian
- A licensed psychological associate
- A nurse first assistant

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.

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 is licensed or certified to practice where the care is provided, is rendering a service within the scope of that license or certification and such license or certification is required to render that service, and is providing a service for which benefits are specified in this booklet.

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 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.

FOR INSURED PERSONS RESIDING IN WYOMING

The following diagnostic screenings or routine tests are not subject to the Calendar Year Deductible and if they are provided by a *non-participating provider*, your Co-Payment will be **20%** of *covered expense*:

1. Prostate cancer examination and laboratory tests.
2. Cervical cancer examination and pap smear.
3. Breast cancer examinations, including a screening mammogram and clinical breast examination.
4. Colorectal cancer examination and laboratory tests.

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