# *Benefits Enhancement Rider*

Your *Certificate of Coverage* is amended as described in this document. This Rider becomes a part of your Contract and is subject to all provisions. Please refer to all sections of your Contract, including your *Outline of Coverage*, for guidelines on coverage and Cost-Sharing details.

## 1. Infertility Treatment

### General Exclusions

The chapter in your Certificate entitled "General Exclusions" is hereby amended.

The following exclusion is STRICKEN:

Infertility services. This includes, but is not limited to:

- medications for treatment of infertility such as Clomid, Clomiphene, Serophene, Bravelle, Gonal-F, Follistim AQ, Novarel, Ovidrel, Pregnyl, Profasi and Repronex when used for treatment of infertility; and
- surgical, radiological, pathological or laboratory procedures leading to or in connection with (for example):
  - insemination (intravaginal, intracervical, and intrauterine);
  - in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT);
  - zygote intrafallopian transfer (ZIFT); and
  - any variations of these procedures, including costs associated with collection, washing, preparation or storage of sperm for insemination including donor fees, cryopreservation of donor sperm and eggs.

  Note: This exclusion does not apply to the evaluation to determine if and why a couple is infertile.

The following exclusion is ADDED:

Infertility services. This includes, but is not limited to:

- surgical, radiological, pathological or laboratory procedures leading to or in connection with (for example):
  - insemination (intravaginal, intracervical, and intrauterine);
  - in vitro fertilization, embryo transplantation and gamete intrafallopian transfer (GIFT);
  - zygote intrafallopian transfer (ZIFT); and
  - any variations of these procedures, including costs associated with collection, washing, preparation or storage of sperm for insemination including donor fees, cryopreservation of donor sperm and eggs.

  Note: This exclusion does not apply to the evaluation to determine if and why a couple is infertile.

### Summary

Therefore, the following services are eligible for benefits and subject to the terms and conditions of your Contract, including the guidelines for coverage under your Plan:

- medications for treatment of infertility such as Clomid, Clomiphene, Serophene, Bravelle, Gonal-F, Follistim AQ, Novarel, Ovidrel, Pregnyl, Profasi and Repronex when used for treatment of infertility. Benefits are provided subject to your prescription drug coverage.

## 2. Sterilization

### General Exclusions

The chapter in your Certificate entitled "General Exclusions" is hereby amended.

The following exclusion is STRICKEN:

Sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).

### Summary

Therefore, the following services are eligible for benefits and subject to the terms and conditions of your Contract, including the guidelines for coverage under your Plan:

- sterilization reversal (vasectomy reversal, vasovasostomy, vasovasorrhaphy, tubal ligation reversal, tubotubal anastomosis).

# 3. Non-Covered Surgery

## General Exclusions

The chapter in your Certificate entitled "General Exclusions" is hereby amended.

The following exclusion is STRICKEN:

Unless expressly required by law, we do not cover:

- excision of excessive skin and subcutaneous tissue, and tightening (plication) of underlying structures (includes abdominoplasty, panniculectomy, correction of diastasis rectus, lipectomy and umbilical transposition) of the chest, abdomen, thigh, leg, hip, buttocks, arm, forearm, hand, neck (submental fatpad) and all other areas not specified;
- suction-assisted removal of fatty tissue (lipectomy) in the head, neck, trunk, upper extremity or lower extremity;
- breast lift (mastopexy) except when a necessary component of reconstruction of breasts following breast Surgery;
- Surgery to improve the appearance of the ear (otoplasty);
- repair of brow ptosis, repair of blepharoptosis, correction of lid retraction, reduction of overcorrection of lid ptosis; and
- Surgery to improve the appearance of the nose (rhinoplasty).

  Note: This exclusion does not apply to panniculectomy when the panniculectomy is considered Medically Necessary as an adjunct to other procedures such as ventral herniorrhaphy, provided that the medical necessity criteria for panniculectomy have been met. This exclusion also does not apply to lipectomy performed as part of the treatment of lipedema.

## Summary

Therefore, the following services are eligible for benefits and subject to the terms and conditions of your Contract, including the guidelines for coverage under your Plan:

- excision of excessive skin and subcutaneous tissue, and tightening (plication) of underlying structures (includes abdominoplasty, panniculectomy, correction of diastasis rectus, lipectomy and umbilical transposition) of the chest, abdomen, thigh, leg, hip, buttocks, arm, forearm, hand, neck (submental fatpad) and all other areas not specified;
- suction-assisted removal of fatty tissue (lipectomy) in the head, neck, trunk, upper extremity or lower extremity;
- breast lift (mastopexy) except when a necessary component of reconstruction of breasts following breast Surgery;
- Surgery to improve the appearance of the ear (otoplasty); and
- repair of brow ptosis, repair of blepharoptosis, correction of lid retraction, reduction of overcorrection of lid ptosis; and
- Surgery to improve the appearance of the nose (rhinoplasty).

# 4. Dental Services

## Covered Services

The chapter in your Certificate entitled "Covered Services" is hereby amended by *STRIKING* the section entitled "Dental Services" and *ADDING* the following.

In the event of an emergency, you must contact us as soon as possible afterward for approval of continued treatment. We cover only the following dental services:

- Treatment for, or in connection with, an accidental injury to jaws, sound natural teeth, mouth or face, provided a continuous course of dental treatment begins within six months of the accident.[1]
- Surgery to correct gross deformity resulting from major disease or Surgery (Surgery must take place within six months of the onset of disease or within six months after Surgery and covers a reasonable course of treatment defined as not exceeding five years from the beginning of treatment, except as otherwise required by law).
- Surgery related to head and neck cancer where sound natural teeth may be affected primarily or as a result of the chemotherapy or radiation treatment of that cancer.
- Treatment related to congenital or genetic disorder, such as but not limited to the absence of one or more teeth, up to the first molar, or abnormal enamel (example lateral peg).
- Surgical removal of bone-impacted teeth, including removal of wisdom teeth.
- Gingivectomy only for general or systemic conditions or conditions resulting from the effects of drugs.

[1] A sound, natural tooth is a tooth that is whole or properly restored using direct restorative dental materials (i.e. amalgams, composites, glass ionomers or resin ionomers); is without impairment, untreated periodontal conditions or other conditions; and is not in need of the treatment provided for any reason other than accidental injury. A tooth previously restored with a dental implant, crown, inlay, onlay, or treated by endodontics, is not a sound natural tooth.

- Facility and anesthesia charges for Members with phobias or a mental illness documented by a licensed Physician or mental health Professional; or with severe disabilities that preclude office-based dental care due to safety considerations; or who are developmentally unable to safely tolerate office-based dental care.
- Diagnostics imaging, including but not limited to, plain film radiographs and Cone Beam CT (CBCT), performed as part of evaluation of an accidental injury to the jaws, sound natural teeth, mouth or face, or as part of evaluation to correct gross deformity resulting from major disease or Surgery.

  Note: The Professional charges for the dental services may not be Covered.

You must get Prior Approval for the services listed above. See your Certificate of Coverage, Chapter One, "General Guidelines" for more information regarding Prior Approval and instances where Prior Approval is not required.

## Exclusions

Unless expressly required by law, we do not cover:

- tooth implants, including those for the purpose of anchoring oral appliances (this exclusion does not apply for the treatment of an accidental injury, trauma, cancer-related treatment or diagnosis for which you have received Prior Approval);
- care for periodontitis;
- injury to teeth or gums as a result of chewing or biting;
- pre- and post-operative dental care;
- orthodontics (including orthodontics performed as an adjunct to orthognathic Surgery or in connection with an accidental injury);
- procedures designed primarily to prepare the mouth for dentures (including alveolar augmentation, bone grafting, frame implants and ramus mandibular stapling); or
- charges related to non-Covered dental procedures or anesthesia (for example, facility charges, except when Medically Necessary as noted above).

General Exclusions in Chapter Three of your Certificate of Coverage also apply.

## Summary

Therefore, the following services are eligible for benefits and subject to the terms and conditions of your Contract, including the guidelines for coverage under your Plan:

- Surgical removal of bone-impacted teeth, including removal of wisdom teeth.
- Gingivectomy only for general or systemic conditions or conditions resulting from the effects of drugs.

Don C. George
President and CEO