Benefits Enhancement Rider

Your *Certificate of Coverage* and the accompanying Riders are amended as described in this document. This Rider becomes a part of your Contract and is subject to all its provisions.

I. Infertility Treatment

General Exclusions

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

The following exclusion is stricken:

Infertility Services, including:

- All medications for treatment of infertility, including but not limited to Clomid, Clomiphene, Serophene, Bravelle, Gonal-F, Follistim AQ, Novarel, Ovidrel, Pregnyl, Profasi and Repronex (the four-cycle limitation in your Prescription Drug Rider is hereby stricken) when used for treatment of infertility; and
- Surgical, radiological, pathological or laboratory procedures leading to or in connection with artificial insemination (intravaginal, intracervical, and intrauterine insemination), 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 artificial insemination including donor fees, cryopreservation of donor sperm and eggs.

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

The following exclusion is added:

- Infertility services, including Surgical, radiological, pathological or laboratory procedures or medication leading to or in connection with artificial insemination (intravaginal, intracervical, and intrauterine insemination), 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 artificial insemination including donor fees, cryopreservation of donor sperm and eggs.

This exclusion does not apply to the evaluation to determine if and why the couple is infertile. We may Cover up to four months of fertility medications per calendar year when you attempt to conceive through natural means (not by artificial insemination, in vitro fertilization, embryo transplantation and gamete intrafallopian transfer, zygote intrafallopian transfer or any variations of these procedures). You must get prior approval for the fertility medications.

II. Sterilization

General Exclusions

The following exclusion is stricken from the chapter in your Certificate entitled "General Exclusions":

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

BlueCross BlueShield of Vermont

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Covered Services

The "Notes on Surgery" section within the "Covered Services" chapter in your Certificate has been replaced with the following:

Notes on Surgery:

You must get Prior Approval for the Services listed on your Outline of Coverage, including plastic/Cosmetic and Reconstructive procedures or your care will not be Covered. We Cover sterilization procedures (vasectomy or tubal ligation) even though they are not Medically Necessary.

We limit Surgery Benefits as follows:

- We Cover only one attempt at reversal of sterilization per individual per lifetime.
- We make global payments for some Surgeries and other procedures. This means that our Allowed Price for the Surgery includes payment for all office visits and other care that is related to the Surgery.
- Subject to Medical Necessity, we may limit the number of visits we Cover by one Provider in a given day.
- If you have several Surgeries at the same time, we may not pay a full allowance for each one. If you have questions about the way we determine our Allowed Price for Surgery, please call customer service at the number on the back of your ID card.
- We Cover Services of a Network or Preferred certified nurse midwife (not a lay or professional midwife) or a Physician for home delivery of a baby.
- We exclude many types of Cosmetic procedures (see General Exclusions in Chapter Three).

III. Noncovered Surgery

General Exclusions

The following exclusions found in the "General Exclusions" chapter in your Certificate have been stricken:

Unless expressly covered in other parts of this Contract or required by law, we do not cover:

a. Excision, 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;
b. Suction assisted removal of fatty tissue (lipectomy) in the head, neck, trunk, upper or lower extremity;
c. Breast lift (mastopexy);
d. Surgery to improve the appearance of the ear (otoplasty);
e. Mastectomy for gynecomastia;
f. Blepharoplasty; repair of brow ptosis, repair of blepharoptosis, correction of lid retraction, reduction of overcorrection of lid ptosis; and
g. Surgery to improve the appearance of the nose (rhinoplasty).

Note:

This exclusion does not apply to (1) Surgery when such service is incidental to or follows Surgery resulting from trauma, infection or other diseases of the involved part; or (2) medically diagnosed congenital disease or birth abnormality of a Covered dependent child.

IV. Dental Services

The chapter in your Certificate entitled "Covered Services" is hereby amended by replacing the section of Covered Services entitled Dental Services with the following:

You must get Prior Approval from us for the Services listed on your Outline of Coverage, including dental Services (except wisdom teeth extraction) or your care will not be Covered.

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 is started within six months of the accident.
  Note: A sound, natural tooth is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal conditions, or other conditions; and is not in need of treatment provided for any reason other than accidental injury. A tooth previously restored with a crown, inlay, onlay or porcelain restoration, or treated by endodontics, is not a sound natural tooth;
- 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, except as otherwise required by law);
- Surgical removal of bone-impacted teeth; and
- Gingevectomy only for general or systemic conditions or conditions resulting from the effects of drugs.

Exclusions

Unless expressly Covered in other parts of this Contract or required by law, we do not Cover:

- tooth implants;
- 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);
- 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 (for example, anesthesia or facility charges), except when Medically Necessary for children under seven years old or any members with disabilities, medical or mental health conditions, or exceptional medical circumstances, which prevent care from being safely delivered in an office setting or under local anesthesia.

General Exclusions in Chapter Three also apply. Please remember that the General Exclusions in your Certificate of Coverage also apply.

Don C. George
President and CEO