

**ENDORSEMENT TO THE INDIVIDUAL  
COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM**

**Individual PPO HIPAA \$1,500 – DL97**

**Issued by  
ANTHEM BLUE CROSS**

Effective July 1, 2010, the following revisions have been made to the Individual PPO HIPAA Combined Evidence of Coverage and Disclosure Form one of which has been issued to you by Anthem Blue Cross (“Anthem”).

**PLEASE NOTE: ~~STRIKETHROUGH~~ INDICATES TEXT THAT HAS BEEN REMOVED;  
UNDERLINE INDICATES TEXT THAT HAS BEEN ADDED.**

**Under the part entitled YOUR PRESCRIPTION DRUG BENEFITS the following changes have been made:**

**YOUR PRESCRIPTION DRUG BENEFITS**

Benefits are provided as follows for Prescription Drugs purchased from licensed retail Pharmacies by Members eligible to receive outpatient Prescription Drug benefits under this Combined Evidence of Coverage and Disclosure Form.

Anthem Blue Cross uses a preferred list of Drugs, sometimes called a Formulary, to help your doctor make prescribing decisions. This list of Drugs is updated quarterly by a committee consisting of doctors and Pharmacists so that the list includes Drugs that are safe and effective in the treatment of disease. The presence of a drug on the plan’s formulary does not guarantee that it will be prescribed. If you have a question regarding whether a Drug is on the Anthem Blue Cross Preferred Drug List, please call [the Pharmacy Benefits Manager toll free at 1-800-700-2533](tel:1-800-700-2533) [or access information on our web site at www.anthem.com/ca](http://www.anthem.com/ca).

Some medications may require written Prior Authorization from Anthem Blue Cross. Please call [the Pharmacy Benefits Manager toll free at 1-800-700-2533](tel:1-800-700-2533) for a list [of these Drugs](#).

For an explanation of your Prescription Drug coverage when you are enrolled in Medicare Part D, see the section entitled Non-Duplication of Medicare under the PART entitled EXCLUSIONS AND LIMITATIONS: WHAT IS NOT COVERED BY ANTHEM BLUE CROSS.

**Definitions**

~~**Anthem Blue Cross Negotiated Fee** is the fee that Anthem Blue Cross has negotiated with the Participating Pharmacy under a Participating Pharmacy Agreement for covered Prescriptions. Participating Pharmacies have agreed to charge eligible Blue Cross Members no more than the negotiated fee for covered Prescriptions.~~

~~**Average Wholesale Price (AWP)** is the average of the list prices that the manufacturers producing the Drug suggest that a wholesaler charge a Pharmacy for the Drug.~~

**Brand Name Prescription Drug (Brand Name)** is a Prescription Drug that has been patented.

~~**Drug Limited Fee Schedule** is the maximum amount that Anthem Blue Cross will consider for payment when your Prescription is filled at a Non-Participating Pharmacy and is the lesser of billed charges or the Average Wholesale Price.~~

**Drugs (Prescription Drugs)** mean Prescription Drugs approved by the State of California or the Food and Drug Administration for general use by the public. For purposes of this benefit, Insulin will be deemed a Prescription Drug.

**Formulary** is a list of Drugs which Anthem Blue Cross has determined to be safe and cost-effective based on available medical literature.

**Generic Prescription Drug** (Generic) is a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

**Maintenance Prescription Drugs** are Prescription Drugs which are taken for an extended period of time to treat a medical condition.

**Non-Participating Pharmacy** is a Pharmacy which does not have a Participating Pharmacy Agreement in effect with or for the benefit of Anthem Blue Cross at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

**Participating Pharmacy** is a Pharmacy which has a Participating Pharmacy Agreement in effect with or for the benefit of Anthem Blue Cross at the time services are rendered. Call your local Pharmacy or call customer service at 1-800-700-2533. Some Participating Pharmacies display an Anthem Blue Cross "Rx" decal so that you can easily identify them.

**Pharmacy** means a licensed retail Pharmacy.

**Prescription** means a written order issued by a Physician.

[Prescription Drug Maximum Allowed Amount is the maximum amount we allow for Prescription Drugs. The amount is determined by Anthem Blue Cross using cost information provided to Anthem Blue Cross by the Pharmacy Benefits Manager. The Prescription Drug Maximum Allowed Amount is subject to change. You may determine the Prescription Drug Maximum Allowed Amount of a particular Prescription Drug by calling 1-800-700-2533.](#)

**Self-administered injectable Drugs** are injectable Drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member.

**Your Prescription Drug benefits are as follows:**

#### **Drug Utilization Review**

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require prior authorization. If there are patterns of over-utilization or misuse of Drugs, we will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over-utilization of Drugs.

#### **Brand Name Prescription Deductible**

Each Member must meet a Brand Name Prescription Deductible amount of \$250 each Year. This Deductible is separate from the annual Deductible for medical benefits and does not accumulate towards satisfying the medical Yearly Maximum Copayment/Coinsurance Limit. This Brand Name Prescription Deductible applies to Brand Name Prescription Drugs purchased through the Mail Order Prescription Drug Program and at Participating and Non-Participating Pharmacies combined. However, any Copayment made for a Brand Name Drug that has been specified by your Physician to "dispense as written" or "do not substitute" when a Generic Drug equivalent exists, the [Prescription Drug Maximum Allowed Amount](#)~~Anthem Blue Cross Negotiated Fee (Participating Pharmacies) or the Drug Limited Fee Schedule (Non-Participating Pharmacies)~~ for that Brand Name Drug will **not** be applied towards the Brand Name Prescription Drug Deductible. The first two (2) Members of an enrolled family to satisfy their Brand Name Prescription Deductible in full will satisfy this Deductible for the entire family. Once the family Brand Name Deductible is satisfied, no further Brand Name Deductible is required for the remainder of that Year. However, we will not credit any Brand Name Deductible over and above the family Brand Name Deductible maximum that was applied but did not satisfy an individual Member's Brand Name Deductible amount in full.

## What is Covered

- Outpatient Drugs and medications which Federal and/or State of California law restrict to sale by Prescription only.
- Insulin and syringes prescribed and dispensed for use with Insulin. Lancets and test strips for use in monitoring diabetes.
- All non-infused compound Prescriptions which contain at least one covered Prescription ingredient.
- Oral Contraceptive Drugs prescribed for birth control. If your Physician determines that oral contraceptive Drugs are not medically appropriate, coverage for another FDA approved Prescription contraceptive method will be provided.
- Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction must be authorized in advance by Anthem Blue Cross and are limited to eight (8) tablets/units per 30 day period. **Not covered under Mail Order Prescription Drug Program.**
- Phenylketonuria (PKU) formulas and food products. These formulas are subject to the Copayment for Brand Name Drugs and the Brand Name Prescription Deductible.

**Note:** Generic Drugs will be dispensed by Participating Pharmacies unless the Prescription specifies a Brand Name and states "Dispense as written" or "Do not substitute" or no Generic Drug equivalent exists. However, any Copayment made for a Brand Name Drug that has been specified by your Physician to "dispense as written" or "do not substitute" when a Generic Drug equivalent exists, the [Prescription Drug Maximum Allowed Amount](#)~~Anthem Blue Cross Negotiated Fee (Participating Pharmacies)~~ or the ~~Drug Limited Fee Schedule (Non-Participating Pharmacies)~~ for that Brand Name Drug will **not** be applied towards the Brand Name Prescription Drug Deductible.

## Conditions of Service

The Drug or medicine must:

- Be prescribed in writing by a Physician and be dispensed by a licensed retail pharmacist or by mail through the Mail Order Prescription Drug Program within one year of being prescribed, subject to Federal or State laws.
- Be approved for use by the Food and Drug Administration.
- Be for the direct care and treatment of the Member's illness, injury or condition.
- Not be used while the Member is an inpatient in any facility.

The Prescription must not exceed a 30-day supply unless ordered by mail through the Mail Order Prescription Drug Program, in which case the limit is a 60-day supply.

## When you go to a Participating Pharmacy

When you present your ID card at a Participating Pharmacy, you will have the following Copayment/Coinsurance for each covered Prescription and/or refill:

For Drugs on the Anthem Blue Cross Formulary:

- \$10 Copayment for Generic Drugs.
- 100% of [Prescription Drug Maximum Allowed Amount](#)~~Negotiated Fee Rate~~ for Brand Name Drugs until \$250 Brand Name Prescription Drug Deductible is satisfied
- After \$250 Brand Name Prescription Drug Deductible\*\* is satisfied:
  - \$30 Copayment for Brand Name Drugs if a Generic equivalent is not available.
  - \$10 Copayment **plus** the difference in cost, based on the [Prescription Drug Maximum Allowed Amount](#)~~Negotiated Rate~~ when purchased at a Participating Pharmacy, between the Brand Name and the Generic equivalent for Brand Name Drugs if a Generic equivalent is available.\*
- 30% of the [Prescription Drug Maximum Allowed Amount](#)~~Negotiated Fee Rate~~ for Self-administered injectable Drugs, except Insulin.

For Drugs **not** on the Anthem Blue Cross Formulary:

- 50% of the [Prescription Drug Maximum Allowed Amount](#)~~Negotiated Fee Rate~~ for Generic Drugs.

- 100% of the [Prescription Drug Maximum Allowed Amount](#)~~Negotiated Fee Rate~~ for Brand Name Drugs until \$250 Brand Name Prescription Drug Deductible is satisfied
- After \$250 Brand Name Drug Deductible \*\* has been satisfied:
  - 50% of the [Prescription Drug Maximum Allowed Amount](#)~~Negotiated Fee Rate~~ for Brand Name Drugs if a Generic Equivalent is not available
  - \$10 Copayment **plus** the difference in cost, based on the [Prescription Drug Maximum Allowed Amount](#)~~Negotiated Rate~~ when purchased at a Participating Pharmacy, between the Brand Name and the Generic Equivalent for Brand Name Drugs if a Generic Equivalent is available.
- 30% of the [Prescription Drug Maximum Allowed Amount](#)~~Negotiated Fee Rate~~ for Self-administered injectable Drugs, except Insulin.

**\*Note:**

There are certain drugs that currently have potential equivalency issues. These drugs are called Narrow Therapeutic Index (NTI) drugs. If you purchase an NTI drug from a Participating Pharmacy, even if a Generic equivalent is available, you will be responsible for the Brand Name copayment and your Brand Name Drug Deductible. A list of applicable NTI drugs is available on our website ([www.anthem.com/ca](http://www.anthem.com/ca)) or by calling Pharmacy customer service at 1-800-700-2533.

- \*\* Both Formulary and Non-Formulary brand name drugs count toward the \$250 Brand Name Drug Deductible.

**When you go to a Non-Participating Pharmacy**

If you purchase a Prescription Drug from a Non-Participating Pharmacy, you will have to pay for the full cost of the Drug and submit a claim to:

Anthem Blue Cross Prescription Drug Program  
P.O. Box 4165  
Woodland Hills, CA 91365-4165

Claim forms and customer service are available by calling 1-800-700-2533. Mail the claim form with the appropriate portion completed and signed by the pharmacist to Anthem Blue Cross no later than 15 months after the date of dispensing.

**The rate of reimbursement by Anthem Blue Cross:**

**When your Prescription is filled at a Non-Participating Pharmacy:**

The reimbursement will be 50% of the [Prescription Drug Maximum Allowed Amount](#)~~Drug Limited Fee Schedule amount~~ less the Copayment/Coinsurance as stated for Participating Pharmacies.

**Note:** Refer to the Definitions section of this PART for the definition of [Prescription Drug Maximum Allowed Amount](#)~~Drug Limited Fee Schedule~~.

**When You Order By Mail**

Maintenance Drugs can be purchased through the mail, requiring the following Copayment to be submitted for each Prescription:

- **Generic Drugs:** You pay a \$10 Copayment for each Prescription and/or refill for each 30-day supply or a \$20 Copayment for up to a maximum 60-day supply.
- **Brand Name Drugs:** After \$250 Brand Name Prescription Drug Deductible is satisfied:
  - You pay a \$30 Copayment for each Prescription and/or refill for each 30-day supply or a \$60 Copayment for up to a maximum 60-day supply if a Generic equivalent is not available.
  - You pay a \$10 Copayment **plus** the difference in cost between the Brand Name and the Generic equivalent for each Prescription and/or refill for each 30-day supply or a \$20 Copayment **plus** the difference in cost between the Brand Name and the Generic equivalent for each Prescription and/or refill for up to a maximum 60-day supply if a Generic equivalent is available.

**\*Note:** There are certain drugs that currently have potential equivalency issues. These drugs are called Narrow Therapeutic Index (NTI) drugs. If you purchase an NTI drug from a Participating Pharmacy, even if a Generic equivalent is available, you will be responsible for the Brand Name copayment and your Brand Name Drug Deductible. A list of applicable NTI drugs is available on our website ([www.anthem.com/ca](http://www.anthem.com/ca)) or by calling Pharmacy customer service at 1-800-700-2533.

The first mail order Prescription you submit must include a completed Patient Profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Member need only the Prescription and Copayment to be enclosed. You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail service Pharmacy.

**Note:** Some Prescription Drugs and/or medicines are not available for purchase through the Mail Order Prescription Drug program including: Drugs not on the Formulary, Drugs and medications for the treatment of impotence and/or sexual dysfunction, injectables, including Self-administered Injectables except Insulin, and antibiotics. Please check with the Mail Order Prescription Drug Program Customer Service Department at 1-866-274-6825 for availability of the Drug or medicine.

### **Prescription Drug Exclusions and Limitations**

IN ADDITION TO ANY LIFETIME MAXIMUMS, LIMITATIONS ON PRE-EXISTING CONDITIONS OR ANY OTHER EXCLUSIONS OR LIMITATIONS CONTAINED IN THIS ENTIRE AGREEMENT, PRESCRIPTION DRUGS AND REIMBURSEMENT WILL NOT BE FURNISHED FOR:

- Drugs or medications which may be obtained without a Physician's Prescription, except Insulin and Niacin for cholesterol lowering.
- Prescription Drugs which have non-prescription chemical and dosage equivalents.
- Non-medicinal substances or items.
- Pharmaceuticals to aid smoking cessation (e.g., Nicorette or nicotine patches), over the counter remedies or any Prescription product containing nicotine. While not covered under this Prescription Drug benefit, under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, pharmaceuticals to aid smoking cessation (e.g., Nicorette or nicotine patches) are specified as covered under the section describing benefits for "Smoking Cessation", subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Contraceptive devices prescribed for birth control except as specifically stated under the section entitled What is Covered under this PART entitled YOUR PRESCRIPTION DRUG BENEFITS. Also, under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, contraceptive implants and associated professional services are specified as covered under the section describing benefits for "Professional Services and Supplies", subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Drugs and medications used to induce non-spontaneous abortions. While not covered under this Prescription Drug benefit, FDA approved medications that may only be dispensed by or under direct supervision of a Physician, such as Drugs and medications used to induce non-spontaneous abortions, are specified as covered under the section of the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS describing benefits for "Professional Services and Supplies", subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Dietary Supplements, herbs, vitamins, cosmetics, health or beauty aids, or similar products which are not FDA approved to treat, diagnose, prevent or cure a medical condition. However, you will want to know the following:
  - Under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, formulas for the treatment of phenylketonuria are specified as covered under the section describing benefits for treatment of "Phenylketonuria", subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.



- Under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, health aids that are medically necessary and satisfy the definition of durable medical equipment, will be covered under the section describing benefits for “Medical Supplies and Equipment”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Drugs furnished by a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent Hospital or similar facility. While not covered under this Prescription Drug benefit, if you need Prescription Drugs while in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent Hospital or similar facility, you will want to know the following:
  - Under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, Drugs and medicines furnished to you by a Hospital while you are a patient at a Hospital are specified as covered under the section describing benefits for services and supplies furnished by a Hospital, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
  - Under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, Drugs and medicines furnished to you by a Skilled Nursing Facility while you are a patient at a Skilled Nursing Facility are specified as covered under the section describing benefits for services and supplies furnished by a Skilled Nursing Facility, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
  - In a rest home, sanitarium, convalescent hospital or similar facility, drugs supplied and administered by the Member’s Physician are specified as covered under the section describing benefits for “Professional Services and Supplies”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits. Other drugs that may be prescribed by a Physician for a Member in a rest home, sanitarium, convalescent hospital or similar facility, can be purchased at a Pharmacy by the Member, or a friend, relative or care giver on behalf of the Member, and in such case, benefits will be provided under this Prescription Drug benefit.
- ~~■ Any expense incurred in excess of the Drug Limited Fee Schedule at a Non-Participating Pharmacy.~~
- Any Drug labeled “Caution, limited by Federal law to investigational use.” Non-FDA approved investigational Drugs or any Drug or medication prescribed for experimental indications.
- Syringes and/or needles except those dispensed for use with Insulin. While not covered under this Prescription Drug benefit, under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, these items are covered under the sections describing benefits for “Home Health Care”, “Infusion Therapy”, “Treatment for Diabetes” and/or “Medical Supplies and Equipment”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Durable medical equipment, devices, appliances, and supplies, except lancets and test strips for use in the monitoring of diabetes. While not covered under this Prescription Drug benefit, if you need those items, you will want to know the following:
  - Under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, durable medical equipment, devices, appliances, and supplies are specified as covered under the section describing benefits for “Medical Supplies and Equipment”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
  - Under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, lancets and test strips for use in the monitoring of diabetes are specified as covered under the section describing benefits for “Treatment for Diabetes”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Immunizing agents, biological sera, blood, blood products or blood plasma. Oxygen. While not covered under this Prescription Drug benefit, if you need those items, you will want to know the following:

- Under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, these services are covered under the sections describing benefits for “Professional Services and Supplies”, “Preventive Care”, “Medical Supplies and Equipment”, “Infusion Therapy” and “Well Baby and Well Child Care”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Professional charges in connection with administering, injecting or dispensing of Drugs. Infusion medications. While not covered under this Prescription Drug benefit, under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, these services are specified as covered under the sections describing benefits for “Professional Services and Supplies” and for “Infusion Therapy”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Drugs and medication dispensed or administered in an outpatient setting, including, but not limited to, outpatient Hospital facilities and doctor’s offices. While not covered under this Prescription Drug benefit, if you need such Drugs in an outpatient setting, you will want to know the following:
  - Under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, these drugs are specified as covered under the sections describing benefits for “Professional Services and Supplies”, “Hospital Services” and “Infusion Therapy”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Drugs used for cosmetic purposes (e.g., Retin-A for wrinkles).
- Drugs used for the primary purpose of treating infertility.
- Drugs used for weight loss except for the Medically Necessary treatment of morbid obesity.
- Drugs obtained outside of the United States unless related to a Medical Emergency.
- Allergy desensitization products, allergy serum. While not covered under this Prescription Drug benefit, if you need such Drugs, you will want to know the following:
  - Under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, Drugs (which reference would include allergy desensitization products, allergy serum) are covered under the sections describing benefits for “Professional Services and Supplies”, “Hospital Services” and “Skilled Nursing Facilities”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- All Infusion Therapy except Self-administered injectables and aerosols, is excluded under this Prescription Drug benefit. While not covered under this Prescription Drug benefit, if you need Infusion Therapy, you will want to know the following:
  - Under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, Infusion Therapy is specified as covered under the sections describing benefits for “Professional Services and Supplies” and for “Infusion Therapy”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Treatment of impotence and/or sexual dysfunction must be Medically Necessary and documentation of a confirmed diagnosis of erectile dysfunction must be submitted to Anthem Blue Cross for review. Drugs and medications for treatment of impotence and/or sexual dysfunction are limited to eight (8) tablets/units per 30-day period. **Not covered under Mail Order Prescription Drug Program.**
- Hepatitis B and varicella zoster (chicken pox) vaccines for Members age 7 through 18 and childhood immunizations. While not covered under this Prescription Drug benefit, under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM BLUE CROSS, these immunizing agents are specified as covered under the section describing benefits for “Professional Services and Supplies”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.

**Claims and Customer Service:**

For **Retail Pharmacy** information, please write to:

Anthem Blue Cross Prescription Drug Program  
P.O. Box 4165

Woodland Hills, CA 91365-4165  
or call 1-800-700-2533

For **Mail Order Prescription Drug Program** information, please write to:

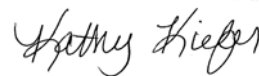
Anthem Blue Cross Mail Order Prescription Drug Program  
P.O. Box 961025  
Fort Worth, TX 76161-9863  
or call 1-866-274-6825

This endorsement becomes effective July 1, 2010. *Please note: All Provisions of the Combined Evidence of Coverage and Disclosure Form, which are not changed by this Endorsement, remain in effect.*

ANTHEM BLUE CROSS



Leslie A. Margolin  
President  
Anthem Blue Cross



Kathy Kiefer  
Secretary  
Anthem Blue Cross