

# Mariners Church

September 01, 2009

## Blue View Vision<sup>SM</sup> Plan



WL-BVA1-509

U6232840A+3--1





## CERTIFICATE OF INSURANCE

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

This Certificate of Insurance, including any amendments and endorsements to it, is a summary of the important terms of your vision plan. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. The Group Policy, of which this certificate is a part, must be consulted to determine the exact terms and conditions of coverage. If you have special health care needs, you should read those sections of the Certificate of Insurance that apply to those needs. Your employer will provide you with a copy of the Group Policy upon request.

Your vision care coverage is insured by Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health). The following pages describe your vision care benefits and includes the limitations and all other *policy* provisions which apply to you. The *insured person* is referred to as “you” or “your,” and Anthem Blue Cross Life and Health as “we,” “us” or “our.” All italicized words have specific *policy* definitions. These definitions can be found in the DEFINITIONS section of this certificate.

**Important Notice:** This is an important document and should be kept in a safe place. Sign your name in the space below when you receive this booklet.

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Signature of Employee

## **COMPLAINT NOTICE**

**Should you have any complaints or questions regarding your coverage, and this certificate was delivered by a broker, you should first contact the broker. You may also contact us at:**

**Anthem Blue Cross Life and Health Insurance Company  
Customer Service  
21555 Oxnard Street  
Woodland Hills, CA 91367  
818-234-2700**

**If the problem is not resolved, you may also contact the California Department of Insurance at:**

**California Department of Insurance  
Claims Service Bureau, 11th Floor  
300 South Spring Street  
Los Angeles, California 90013**

**1-800-927-HELP (4357) – In California**

**1-213-897-8921 – Out of California**

**1-800-482-4833 – Telecommunication Device for the Deaf**

**E-mail Inquiry: “Consumer Services” link at  
[www.insurance.ca.gov](http://www.insurance.ca.gov)**

# TABLE OF CONTENTS

<b>TYPES OF PROVIDERS .....</b>	<b>1</b>
<b>SUMMARY OF BENEFITS.....</b>	<b>2</b>
VISION CARE BENEFITS .....	2
GENERAL INFORMATION.....	4
<b>YOUR VISION CARE BENEFITS .....</b>	<b>5</b>
HOW COVERED VISION EXPENSE IS DETERMINED.....	5
VISION CARE CO-PAYMENTS AND BENEFIT MAXIMUMS.....	5
HOW TO USE YOUR VISION CARE BENEFITS .....	5
CONDITIONS OF COVERAGE .....	6
VISION CARE THAT IS COVERED .....	7
VISION CARE THAT IS NOT COVERED.....	8
<b>HOW COVERAGE BEGINS AND ENDS.....</b>	<b>10</b>
HOW COVERAGE BEGINS .....	10
HOW COVERAGE ENDS .....	14
<b>CONTINUATION OF COVERAGE.....</b>	<b>16</b>
<b>GENERAL PROVISIONS .....</b>	<b>22</b>
<b>BINDING ARBITRATION .....</b>	<b>25</b>
<b>DEFINITIONS .....</b>	<b>26</b>
<b>FOR YOUR INFORMATION.....</b>	<b>28</b>



## TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS VISION CARE MAY BE OBTAINED. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS BOOKLET ENTITLED DEFINITIONS.

**Participating Vision Care Providers.** Anthem Blue Cross Life and Health has contracted with various *vision care providers* to provide a network of "Participating Vision Care Providers." These providers are called "participating" because they have agreed to participate in our participating provider program (PPO), which we call Blue View Vision. They have agreed to provide *insured persons* with vision care at a negotiated fee. The amount of benefits payable under this *plan* will be different for *non-participating vision care providers* than for *participating vision care providers*.

To find a *participating vision care provider*, you may call us at the customer service number listed on your ID card or you may also search for a *participating vision care provider* using the "Provider Finder" function on our website at [www.anthem.com/ca](http://www.anthem.com/ca).

**Non-Participating Vision Care Providers.** *Non-participating vision care providers* are providers which have not agreed to participate in our network. They have not agreed to the *negotiated rates* and other provisions. You will be responsible for any amounts they charge in excess of our payment.

## SUMMARY OF BENEFITS

THE BENEFITS OF THIS CERTIFICATE ARE PROVIDED ONLY FOR SERVICES WHICH ARE SPECIFIED IN THIS CERTIFICATE AS COVERED SERVICES. THE FACT THAT YOUR VISION CARE PROVIDER PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT A COVERED SERVICE OR A COVERED VISION EXPENSE.

This summary provides a brief outline of your benefits. You need to refer to the entire certificate for complete information about the benefits, conditions, limitations and exclusions of your *plan*.

### VISION CARE BENEFITS

Your vision care benefits cover eye examinations and eyewear only. You can choose to have your eyewear services provided by *participating vision care providers* or by *non-participating vision care providers*; however, your benefits will be affected by this choice.

### CO-PAYMENTS

#### Participating Vision Care Provider Co-Payments

- Comprehensive vision exam ..... **\$10**
- Lenses and frame ..... **\$10\***
- Contact lenses ..... **No co-payment**

\* If you select progressive lenses, there will be an additional **\$65** co-payment.

**Note:** In addition to the Co-Payment shown above, you will be required to pay any amount in excess of the vision care benefit maximums for vision care services. But, when you go to a *participating vision care provider*, your cost for vision care services and supplies in excess of the benefit maximum will be at discount prices.

**Non-Participating Vision Care Provider Co-Payments.** There will be no co-payment required for services and supplies provided by a *non-participating vision care provider*, but, you will responsible for any billed charge which exceeds the Vision Care Benefit Maximum.

## VISION CARE BENEFIT MAXIMUMS

We will pay benefits, for the following services and materials, up to the maximum dollar amounts and benefit periods shown below:

### Participating Vision Care Provider

- Comprehensive vision exam ..... one exam  
per 12-month period\*
- Frames..... **\$130.00**  
one frame per 12-month period\*
- Prescription lenses ..... one pair  
per 12-month period\*
  - Single vision lenses..... **Covered in full**
  - Bi-focal lenses..... **Covered in full**
  - Progressive lenses..... **Covered in full**
  - Tri-focal lenses..... **Covered in full**
- Non-elective contact lenses..... **Covered in full**  
once per 12-month period\*
- Elective contact lenses\*\* ..... **\$130.00**  
once per 12-month period\*

\* From the last date of service.

\*\* Contact lenses are in lieu of eyeglasses. If you choose elective contact lenses in a benefit period, we will not pay benefits for eyeglasses (lenses and frame) during that same benefit period.

### Non-Participating Vision Care Provider

- Comprehensive vision exam ..... **\$49.00**  
one exam per 12-month period\*
- Frames..... **\$50.00**  
one frame per 12-month period\*
- Prescription lenses ..... one pair  
per 12-month period\*
  - Single vision lenses..... **\$35.00**
  - Bi-focal lenses..... **\$49.00**
  - Progressive lenses..... **\$49.00**

- Tri-focal lenses.....**\$74.00**
- Non-elective contact lenses.....**\$250.00**  
once per 12-month period\*
- Elective contact lenses\*\* .....**\$92.00**  
once per 12-month period\*

\* From the last date of service.

\*\* Contact lenses are in lieu of eyeglasses. If you choose elective contact lenses in a benefit period, we will not pay benefits for eyeglasses (lenses and frame) during that same benefit period.

### **GENERAL INFORMATION**

**Contributions**—The insurance for you and your *family members* is *contributory insurance*. You will be informed of the amount of your contribution when you enroll.

#### **Anthem Blue Cross Life and Health’s Address—**

Anthem Blue Cross Life and Health Insurance Company  
 Group Services  
 P.O. Box 70000  
 Van Nuys, California 91470

# YOUR VISION CARE BENEFITS

## HOW COVERED VISION EXPENSE IS DETERMINED

*Covered vision expense* is based on a maximum charge for each covered service or materials which we will accept. It is not necessarily the amount a vision care provider bills for the service. Expense is incurred on the date you receive the service or materials for which the charge is made.

**Participating Vision Care Providers.** The maximum *covered vision expense* for services provided by a *participating vision care provider* will be the lesser of the billed charge or the *negotiated rate*. *Participating vision care providers* have agreed not to charge you more than the *negotiated rate* for covered services.

If you choose frames or lenses that cost more than the Vision Care Benefit Maximum, you will pay the excess at a discounted price. If you choose vision options that are not covered under this *plan*, you will be charged a discounted price.

**Non-Participating Vision Care Providers.** The maximum *covered vision expense* for services provided by a *non-participating vision care provider* will always be the lesser of the billed charge or the Vision Care Benefit Maximum shown in the SUMMARY OF BENEFITS. You will be responsible for any billed charge which exceeds the Vision Care Benefit Maximum.

**You will always be responsible for expense incurred which is not covered under this *plan*.**

## VISION CARE CO-PAYMENTS AND BENEFIT MAXIMUMS

After we subtract your Co-Payment, we will pay benefits up to the amount of *covered vision expense*, not to exceed the applicable Vision Care Benefit Maximum. The Co-Payments and Vision Care Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

## HOW TO USE YOUR VISION CARE BENEFITS

**When You Go to a Participating Vision Care Provider.** To identify you as an insured covered for vision care benefits, you will be issued an identification card. You must present this card to *participating vision care providers* when you go for your appointment. A *participating vision care provider* will only charge your Co-Payment and any charges in excess of the Vision Care Benefit Maximum. When a *participating vision care provider* bills us for covered services, we will pay them directly.

**When You Go to a Non-Participating Vision Care Provider.** If you go to a *non-participating vision care provider* for services, you will have to pay the full cost of the eye examination and/or for any lenses you purchase. You should make copies of the bills for your own records and attach the original bills to the receipt. Send us the receipt with your ID number, at the address below:

**Anthem Blue Cross Life and Health Insurance Company  
Blue View Vision  
P.O. Box 8504  
Mason, OH 45040-7111**

You must send us your receipt from the *vision care provider* with your ID number within 90 days of the date of exam and/or purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

### **CONDITIONS OF COVERAGE**

The following conditions of coverage must be met for expense incurred for services or supplies to be considered as *covered vision expense*.

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or materials for which the charge is made.
2. The expense must be for a routine care of the eye, not for surgery or medical care.
3. The expense must be for a vision service or materials included in VISION CARE THAT IS COVERED. Additional limits on *covered vision expense* are included under specific benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a vision service or materials listed in VISION CARE THAT IS NOT COVERED. If the service or materials are partially excluded, then only that portion which is not excluded will be considered *covered vision expense*.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
6. All services and materials must be ordered by a licensed ophthalmologist, optometrist or dispensing optician.

## VISION CARE THAT IS COVERED

Subject to the Vision Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under VISION CARE THAT IS NOT COVERED, we will provide benefits for the following services and materials:

**Vision Examination.** A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of correction eyewear where indicated. This does not include contact lens fitting fee.

**Frames.** The *vision care provider* will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency. If you go to a *participating vision care provider* and you choose frames that cost more than the benefit maximum shown under SUMMARY OF BENEFITS: VISION CARE BENEFIT MAXIMUMS, your cost will be based on a discounted arrangement.

**Lenses.** The *vision care provider* will order the proper lenses necessary for your visual welfare. The *vision care provider* will verify the accuracy of the finished lenses. Covered lenses include plastic (CR39):

1. Single vision;
2. Bifocal;
3. Trifocal (FT25-28); or
4. Progressive lenses.

Tints, coating and other lens materials and treatments are not covered benefits. You will be responsible for amounts in excess of the Vision Care Benefit Maximum.

Polycarbonate lenses prescribed for a covered dependent *child* age 19 and under are covered in full.

**Elective Contact Lenses.** You have an allowance per benefit period toward cosmetic contact lenses selected in lieu of frame and lens benefit. If you choose contact lenses greater than the *plan* allowance, you are responsible for the difference. If you choose to receive contact lenses during a *calendar year*, no benefits will be paid for lenses and frames during that same *calendar year*.

**Note:** The contact lens benefit is paid toward materials first; any remaining amount will be applied to professional fitting fees. Professional fitting fees are not a covered service, but may be covered or partially covered by applying any remaining contact lens allowance unused for the materials (lens) purchase.

**Non-Elective Contact Lenses.** Non-elective lenses are provided for reasons that are not cosmetic in nature and have a maximum benefit per benefit period. Non-elective contact lenses are covered when the following conditions have been identified or diagnosed:

1. Extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses; or
2. Keratoconus - unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; or
3. High Ametropia - unusually high levels of near sightedness, far sightedness, or
4. Anisometropia - when one eye requires a much different prescription than the other eye.

### **VISION CARE THAT IS NOT COVERED**

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

**Experimental or Investigative.** Any *experimental* or *investigative* services or materials.

**Crime or Nuclear Energy.** Conditions that result from: (1) your commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

**Uninsured.** Services received before your *effective date* or after your coverage ends.

**Excess Amounts.** Any amounts in excess of *covered vision expense*.

**Routine Exams or Tests.** Routine examinations required by an employer in connection with your employment.

**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.

**Government Treatment.** Any services actually given to you by a local, state or federal government agency, except when payment under this *plan* is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.

**Services of Relatives.** Professional services or supplies received from a person who lives in your home or who is related to you by blood or marriage.

**Voluntary Payment.** Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance coverage.

**Not Specifically Listed.** Services not specifically listed in this *plan* as covered services.

**Private Contracts.** Services or supplies provided pursuant to a private contract between the *insured person* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

**Eye Surgery.** Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

**Sunglasses.** Sunglasses and accompanying frames.

**Safety Glasses.** Safety glasses and accompanying frames.

**Hospital Care.** Inpatient or outpatient hospital vision care.

**Orthoptics.** Orthoptics or vision training and any associated supplemental testing.

**Non-Prescription Lenses.** Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

**Cosmetic Options.** Blended lenses/no line, oversize lenses, progressive multifocal lenses, photochromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes, and UV-protected lenses.

**Lost or Broken Lenses or Frames.** Any lost or broken lenses or frames, unless you have reached a new benefit period.

# HOW COVERAGE BEGINS AND ENDS

## HOW COVERAGE BEGINS

### ELIGIBLE STATUS

1. **Insured Employees.** The provisions describing which employees are eligible to enroll as *insured employees* under this *plan* are set forth in the *policy* which is issued to the *group*. (These provisions are not included in this booklet because it is intended for distribution to *insured employees* whose coverage has already become effective.)
2. **Family Members.** The following are eligible to enroll as *family members*: (a) Either the *employee's spouse or domestic partner*; and (b) An unmarried *child*.

### Definition of Family Member

1. **Spouse** is the *employee's spouse* under a legally valid marriage between persons of the opposite sex. Spouse does not include any person who is: (a) covered as an *insured employee*; or (b) in active service in the armed forces.
2. **Domestic partner** is the *employee's domestic partner* under a legally registered and valid domestic partnership. Domestic partner does not include any person who is: (a) covered as an *insured employee*; or (b) in active service in the armed forces.
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 depends on the *employee, spouse or domestic partner* for financial support or the *employee, spouse or domestic partner* is legally required to provide group health coverage for the child pursuant to an administrative or court order. A child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.
  - b. The unmarried child is under 19 years of age, or if age 19 or over, that child is eligible until his or her 25th 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. An

unmarried child 19 years of age, but, less than 25 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 19 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 60-days of the date the *employee* receives our request. We may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. 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, 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.

- f. The term "child" does not include: (i) any person who is covered as an *employee*; or (ii) any person who is in active service in the armed forces.
- g. If both parents are covered as *employees*, their children may be covered as the *family members* of either, but not of both.

## ELIGIBILITY DATE

1. **For Employees:** You become eligible for coverage as set forth in the *policy* which is issued to the *group*. (These provisions are not included in this booklet because it is intended for distribution to *employees* whose coverage has already become effective.)
2. **For Family Members:** You become eligible for coverage on the later of: (a) the date the *employee* becomes eligible for coverage; or (b) the date you meet the *family member* definition.

## ENROLLMENT

To enroll as an *employee*, or to enroll *family members*, the *employee* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *group* within 31 days from your eligibility date. We must receive this application from the *group* within 90 days. If any of these steps are not followed, your coverage may be denied.

## EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of premium on your behalf. The date you become covered is determined as follows:

1. **Timely Enrollment.** If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for *employees*, on your eligibility date; and (b) for *family members*, on the later of (i) the date the *employee's* coverage begins, or (ii) the first day of the month after the *family member* becomes eligible. If you become eligible before the *policy* takes effect, coverage begins on the effective date of the *policy*, provided the enrollment application is on time and in order.
2. **Late Enrollment.** If you fail to enroll within 31 days after your eligibility date, you must wait until the *group's* next Open Enrollment Period to enroll.
3. **Disenrollment.** If you voluntarily choose to disenroll from coverage under this *plan*, you will be eligible to reapply for coverage as set

forth in the “Enrollment” provision above, during the *group’s* next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

For late enrollees and disenrollees: You may enroll earlier than the *group’s* next Open Enrollment Period if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

### **Special Enrollment Periods**

You may enroll without waiting for the *group’s* next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
  - a. You were covered under another vision plan as an individual or dependent, including coverage under a COBRA continuation, the Healthy Families Program, or no share-of-cost Medi-Cal coverage.
  - b. Your coverage under the other vision plan wherein you were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under a COBRA continuation was exhausted, you lost coverage under the Healthy Families Program as a result of exceeding the program’s income or age limits, or you lost no share-of-cost Medi-Cal coverage.
  - c. You properly file an application with the *group* within 31 days from the date on which you lose coverage.
2. A court has ordered coverage be provided for a *spouse*, *domestic partner* or dependent *child* under your employee vision plan and an application is filed within 31 days from the date the court order is issued.
3. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a *child*:
  - a. If you are enrolling following marriage or domestic partnership, you and your new *spouse* or *domestic partner* must enroll within 31 days of the date of marriage or domestic partnership. Your new *spouse* or *domestic partner’s* children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Coverage will be effective on the first day of the month following the date you file the enrollment application.

- b. If you are enrolling following the birth, adoption, or placement for adoption of a *child*, your *spouse* (if you are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption; coverage will be effective as of the date of birth, adoption, or placement for adoption.

## **OPEN ENROLLMENT PERIOD**

The *group* has an open enrollment period once each *year*. During that time, an individual who meets the eligibility requirements as an *employee* under this *plan* may enroll. An *employee* may also enroll any eligible *family members* at that time. Persons eligible to enroll as *family members* may enroll only under the *employee's plan*.

For anyone so enrolling, coverage under this *plan* will begin on the first day of the month following the end of the Open Enrollment Period. Coverage under the former plan ends when coverage under this *plan* begins.

## **HOW COVERAGE ENDS**

Your coverage ends, without notice from us, as provided below:

1. If the *policy* terminates, your coverage ends at the same time. The *policy* may be cancelled or changed without notice to you.
2. If the *group* no longer provides coverage for the class of *insured persons* to which you belong, your coverage ends on the effective date of that change. If this *policy* is amended to delete coverage for *family members*, a *family member's* coverage ends on the effective date of that change.
3. Coverage for *family members* ends when the *employee's* coverage ends.
4. Coverage ends at the end of the period for which premium has been paid to us on your behalf when the required premium for the next period is not paid.
5. If you voluntarily cancel coverage at any time, coverage ends on the premium due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.
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.

## Exceptions to Item 6:

- a. **Leave of Absence.** If you are an *insured employee* and the *group* pays premium to us on your behalf, your coverage may continue for up to six months during a temporary leave of absence approved by the *group*.
- b. **Handicapped Children.** If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan*, (ii) still chiefly dependent on the *insured employee, spouse* or *domestic partner* for support and maintenance, and (iii) incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* has a physical or mental condition that makes the *child* incapable of obtaining self-sustaining employment. We will notify the *insured employee* that the *child's* coverage will end when the *child* reaches the *plan's* upper age limit at least 90-days prior to the date the *child* reaches that age. The *insured employee* must send proof of the *child's* physical or mental condition within 60-days of the date the *insured employee* receives our request. If we do not complete our determination of the *child's* continuing eligibility by the date the *child* reaches the *plan's* upper age limit, the *child* will remain covered pending our determination. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *insured employee, spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.
- c. **Full time students taking a medical leave of absence from school:** If a *child* who is 19 years of age or more, 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), and covered under this *plan* in accordance with the "Eligible Status" provision of this section, the *child* may remain covered under this *plan* for a period not to exceed 12 months or until the date the *child's* coverage would normally end in accordance with the terms and conditions of this *plan*, whichever comes first, during a medical leave of absence from school. This provision applies if the nature of the *child's* health condition does not meet the requirements of the "Handicapped Children"

provision, above. The period of coverage during this medical leave of absence will begin on the first day of the leave or on the date a *physician* determines the child's illness, injury, or condition prevented the *child* from attending school, whichever comes first. Any break in the school calendar will not disqualify the *child* from maintaining coverage under this provision. A *physician* must certify in writing that the leave of absence from school is medically necessary. This certification must be submitted to us at least 30 days prior to the date the leave begins if the medical reason for the leave and the leave itself are foreseeable. If the medical reason for the leave and the leave itself are not foreseeable, the certification must be submitted to us within 30 days after the date the leave begins.

**Note:** If a marriage or domestic partnership terminates, the *employee* must give or send to the *group* written notice of the termination. Coverage for a former *spouse* or *domestic partners*, and their dependent *children*, if any, ends according to the "Eligible Status" provisions. If Anthem Blue Cross Life and Health suffers a loss because of the *employee* failing to notify the *group* of the termination of their marriage or domestic partnership, Anthem Blue Cross Life and Health may seek recovery from the *employee* for any actual loss resulting thereby. Failure to provide written notice to the *group* will not delay or prevent termination of the marriage or domestic partnership. If the *employee* notifies the *group* in writing to cancel coverage for a former *spouse* or *domestic partner* and the children of the *spouse* or *domestic partner*, if any, immediately upon termination of the *employee's* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE.

## CONTINUATION OF COVERAGE

Most employers who employ 20 or more people on a typical business day are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the *policy* is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to a period of continuation of coverage. Check with your employer for details.

## DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "Definitions" provision.

**Initial Enrollment Period** is the period of time following the original Qualifying Event, as indicated in the "Terms of COBRA Continuation" provisions below.

**Qualified Beneficiary** means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *policy* as either an *insured employee* or *insured family member*; and (b) a *child* who is born to or placed for adoption with the *insured employee* during the COBRA continuation period. Qualified Beneficiary does not include: (a) any person who was not enrolled during the Initial Enrollment Period, including any *family members* acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above; or (b) a *domestic partner*, or a *child* of a *domestic partner*, if they are eligible under HOW COVERAGE BEGINS AND ENDS.

**Qualifying Event** means any one of the following circumstances which would otherwise result in the termination of your coverage under the *policy*. The events will be referred to throughout this section by number.

**1. For Insured Employees and Insured Family Members:**

- a. The *employee's* termination of employment, for any reason other than gross misconduct; or
- b. A reduction in the *employee's* work hours.

**2. For Retired Employees and their Insured Family Members.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group's* filing for Chapter 11 bankruptcy, provided:

- a. The *policy* expressly includes coverage for retirees; and
- b. Such cancellation or reduction of benefits occurs within one year before or after the *group's* filing for bankruptcy.

**3. For Insured Family Members:**

- a. The death of the *insured employee*;
- b. The *spouse's* divorce or legal separation from the *employee*;
- c. The end of a *child's* status as a dependent *child*, as defined by the *policy*; or
- d. The *employee's* entitlement to Medicare.

## ELIGIBILITY FOR COBRA CONTINUATION

An *insured employee* or *insured family member*, **other than a *domestic partner*, and a *child of a domestic partner***, may choose to continue coverage under the *policy* if his or her coverage would otherwise end due to a Qualifying Event.

## TERMS OF COBRA CONTINUATION

**Notice.** The *group* or its administrator (we are not the administrator) will notify either the *insured employee* or *insured family member* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the *group* or its administrator will notify the *employee* of the right to continue coverage.
2. For Qualifying Events 3(a) or 3(d) above, a *family member* will be notified of the COBRA continuation right.
3. You must inform the *group* within 60 days of Qualifying Events 3(b) or 3(c) above, if you wish to continue coverage. The *group*, in turn, will promptly give you official notice of the COBRA continuation right.

If you choose to continue coverage you must notify the *group* within 60 days of the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for all *insured persons* within a family, or only for selected *insured persons*.

If you fail to elect the COBRA continuation during the Initial Enrollment Period, you may not elect the COBRA continuation at a later date.

Notice of continued coverage, along with the initial premium, must be delivered to us by the *group* within 45 days after you elect COBRA continuation coverage.

**Additional Insured Family Members.** A *spouse* or *child* acquired during the COBRA continuation period is eligible to be enrolled as a *family member*. The standard enrollment provisions of the *policy* apply to enrollees during the COBRA continuation period.

**Cost of Coverage.** The *group* may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the "premium", must be remitted to the *group* each month during the COBRA continuation period. We must receive payment of the premium each month from the *group* in order to maintain the coverage in force.

Besides applying to the *insured employee*, the *employee's* premium rate will also apply to:

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *employee*;
2. A *child*, if neither the *employee* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the premium will be the two-party or three-party rate depending on the number of *children* enrolled); and
3. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

**Subsequent Qualifying Events.** Once covered under the COBRA continuation, it's possible for a second Qualifying Event to occur. If that happens, an *insured person*, who is a Qualified Beneficiary, may be entitled to an extended COBRA continuation period. This period will in no event continue beyond 36 months from the date of the first qualifying event.

For example, a *child* may have been originally eligible for this COBRA continuation due to termination of the *insured employee's* employment, and was enrolled for this COBRA continuation as a Qualified Beneficiary. If, during the COBRA continuation period, the *child* reaches the upper age limit of the *plan*, the *child* is eligible for an extended continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

**When COBRA Continuation Coverage Begins.** When COBRA continuation coverage is elected during the Initial Enrollment Period and the premium is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For *family members* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *policy*.

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

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;\*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *insured employee*, divorce or legal separation, or the end of dependent *child* status;\*

3. The end of 36 months from the date the *insured employee* became entitled to Medicare, if the Qualifying Event was the *employee's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *insured employee* will end 36 months from the date the *insured employee* became entitled to Medicare;
4. The date the *policy* terminates;
5. The end of the period for which premiums are last paid;
6. The date, following the election of COBRA, the *insured person* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *insured person*, in which case this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
7. The date, following the election of COBRA, the *insured person* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

\*For an *insured person* whose COBRA continuation coverage began under a *prior plan*, this term will be dated from the time of the Qualifying Event under that *prior plan*.

Subject to the *policy* remaining in effect, a retired *employee* whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered *family members* may continue coverage for 36 months after the *employee's* death. However, coverage could terminate prior to such time for either *employee* or *family member* in accordance with items 4, 5 or 6 above.

## **EXTENSION OF CONTINUATION DURING TOTAL DISABILITY**

If at the time of termination of employment or reduction in hours, or at any time during the first 60 days of the COBRA continuation, a Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered *insured persons* may be entitled to up to 29 months of continuation coverage after the original Qualifying Event.

**Eligibility for Extension.** To continue coverage for up to 29 months from the date of the original Qualifying Event, the disabled *insured person* must:

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and

2. Be determined and certified to be so disabled by the Social Security Administration.

**Notice.** The *insured person* must furnish the *group* with proof of the Social Security Administration's determination of disability during the first 18 months of the COBRA continuation period and no later than 60 days after the later of the following events:

1. The date of the Social Security Administration's determination of the disability;
2. The date on which the original Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses coverage; or
4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

**Cost of Coverage.** For the 19th through 29th months that the total disability continues, the *group* must remit the cost for the extended continuation coverage to us. This cost (called the "premium") shall be subject to the following conditions:

1. If the disabled *insured person* continues coverage during this extension, this rate shall be **150%** of the applicable rate for the length of time the disabled *insured person* remains covered, depending upon the number of covered dependents. If the disabled *insured person* does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.
2. The cost for extended continuation coverage must be remitted to us by the *group* each month during the period of extended continuation coverage. We must receive timely payment of the premium each month from the *group* in order to maintain the extended continuation coverage in force.
3. The *group* may require that you pay the entire cost of the extended continuation coverage.

If a second Qualifying Event occurs during this extended continuation, the total COBRA continuation may continue for up to 36 months from the date of the first Qualifying Event. The premium rate shall then be **150%** of the applicable rate for the 19th through 36th months if the disabled *insured person* remains covered. The charge will be **102%** of the applicable rate for any periods of time the disabled *insured person* is not covered following the 18th month.

**When The Extension Ends.** This extension will end at the earlier of:

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;
2. The end of 29 months from the Qualifying Event\*;
3. The date the *policy* terminates;
4. The end of the period for which premiums are last paid;
5. The date, following the election of COBRA, the *insured person* first becomes covered under the other group health plan, unless the other group health plan contains an exclusion or limitation to a pre-existing condition of the *insured person*, in which case this COBRA extension will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
6. The date, following the election of COBRA, the *insured person* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

You must inform the *group* within 30 days of a final determination by the Social Security Administration that you are no longer totally disabled.

## GENERAL PROVISIONS

**Providing of Care.** We are not responsible for providing any type of vision care, nor are we responsible for the quality of any such care received.

**Independent Contractors.** Our relationship with providers is that of an independent contractor. Ophthalmologists, optometrists and dispensing opticians are not our agents nor are we or any of our employees, an employee or agent of any *vision care provider* of any type.

**Non-Regulation of Providers.** The benefits of this *plan* do not regulate the amounts charged by providers of vision care, except to the extent that rates for covered services are regulated with *participating vision care providers*.

### Terms of Coverage

1. In order for you to be entitled to benefits under the *policy*, both the *policy* and your coverage under the *policy* must be in effect on the date the expense giving rise to a claim for benefits is incurred.

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The *policy* is subject to amendment, modification or termination according to the provisions of the *policy* without your consent or concurrence.

**Protection of Coverage.** We do not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; and (3) your premiums are paid according to the terms of the *policy*.

**Free Choice of Provider.** This *plan* in no way interferes with your right as an *insured person* entitled to vision care benefits to select a *vision care provider*. You may choose any *vision care provider* which provides care covered under this *plan*, and is properly licensed according to appropriate state and local laws. But your choice may affect the benefits payable according to this *plan*.

**Expense in Excess of Benefits.** We are not liable for any expense you incur in excess of the benefits of this *plan*.

**Benefits Not Transferable.** Only *insured persons* are entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

**Notice of Claim and Proof of Loss.** You or the *vision care provider* must send us an itemized bill within 90 days of the date you receive the service or supply for which claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. Except in the absence of legal capacity, we are not liable for the benefits of the *plan* if you do not file claims within the required time period. We will not be liable for benefits if we do not receive written proof of loss on time. Canceled checks or receipts are not acceptable.

**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.

**Payment to Providers.** We will pay the benefits of this *plan* directly to *participating vision care providers*. Also, we will pay *non-participating vision care providers* directly when you assign benefits in writing. These payments will fulfill our obligation to you for those covered services.

**Right of Recovery.** When the amount we paid exceeds our liability under this *plan*, we have the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

**Plan Administrator - COBRA and ERISA.** In no event will we be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the *group* or to a person or entity other than us, engaged by the *group* to perform or assist in performing administrative tasks in connection with the *group's* health plan. The *group* is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this booklet, the *group* is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

**Workers' Compensation Insurance.** The *policy* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

**Entire Contract.** This certificate, including any amendments and endorsements to it, is a summary of your benefits. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. All benefits are subject in every way to the entire *policy* which includes this certificate. The terms of the *policy* may be changed only by a written endorsement signed by one of our authorized officers. No agent or employee has any authority to change any of the terms, or waive the provisions of, the *policy*.

**Liability For Statements.** No statements made by you, unless they appear on a written form signed by you or are fraudulent, will be used to deny a claim under the *policy*. Statements made by you will not be deemed warranties. With regard to each statement, no statement will be used by us in defense to a claim unless it appears in a written form signed by you and then only if a copy has been furnished to you. After two years following the filing of such claim, if the coverage under which such claim is filed has been in force during that time, no such statement will be used to deny such a claim, unless the statement is fraudulent.

**Physical Examination.** At our expense, we have the right and opportunity to examine any *insured person* claiming benefits when and as often as reasonably necessary while a claim is pending.

**Legal Actions.** No attempt to recover on the *plan* through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this *plan*. No such action may be started later than three years from the time written proof of loss is required to be furnished.

**Financial Arrangements with Providers.** Under arrangements with some health care providers and suppliers (hereafter referred to together as "Providers") certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, vision services rebates, may be based on utilization of specific Providers for specified vision services rendered to all persons who have coverage through a similar vision program provided or administered by Anthem Blue Cross Life and Health or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by Anthem Blue Cross Life and Health or an affiliate in determining its fees or subscription charges or premiums.

## **BINDING ARBITRATION**

**Note:** If you are enrolled in a *plan* provided by your employer that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. You may pursue voluntary binding arbitration after you have completed an appeal under ERISA. If you have any other dispute which does not involve an adverse benefit decision, this BINDING ARBITRATION provision applies.

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or the *policy*, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

The *insured person* and Anthem Blue Cross Life and Health agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

The *insured person* and Anthem Blue Cross Life and Health agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the *insured person* waives any right to pursue, on a class basis, any such controversy or claim against Anthem Blue Cross Life and Health and Anthem Blue Cross Life and Health waives any right to pursue on a class basis any such controversy or claim against the *insured person*.

The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the *insured person* making written demand on Anthem Blue Cross Life and Health. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the *insured person* and Anthem Blue Cross Life and Health, or by order of the court, if the *insured person* and Anthem Blue Cross Life and Health cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem Blue Cross Life and Health will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to Anthem Blue Cross Life and Health Insurance Company, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department listed on your identification card.

## DEFINITIONS

The meanings of key terms used in this certificate are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in your certificate, you should refer to this section.

**Child** meets the *plan’s* eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

**Contributory Insurance; non-contributory insurance.** Contributory insurance is insurance for which the *group* has the right to require your contributions. Non-contributory insurance is insurance for which the *group* does not have the right to require your contributions. The Summary of Benefits shows whether insurance under a coverage is *contributory insurance* or *non-contributory insurance*.

**Covered vision expense** is the expense you incur for a covered service or materials, but not more than the maximum amounts described in YOUR VISION CARE BENEFITS: HOW COVERED VISION EXPENSE IS DETERMINED. Expense is incurred on the date you receive the service or materials.

**Domestic partner** meets the *plan's* eligibility requirements for domestic partners as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

**Effective date** is the date your coverage begins under this *plan*.

**Experimental** procedures are those that are mainly limited to laboratory and/or animal research.

**Group** refers to the business entity to which we have issued this *policy*.

**Insured employee (employee)** is the primary insured; that is, the person who is allowed to enroll under this *plan* for himself or herself and his or her eligible *family members*.

**Insured family member (family member)** meets the *plan's* eligibility requirements for family members as outlined under HOW COVERAGE BEGINS AND ENDS.

**Insured person** is the *insured employee* or *insured family member*.

**Investigative** procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

**Negotiated rate** is the amount *participating vision care providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Preferred Provider Organization Plan Participating Agreements.

**Non-participating vision care provider** is a provider which does not have a Preferred Provider Agreement with us at the time services are rendered.

**Participating vision care provider** is a provider which has a Preferred Provider Organization Plan Participating Agreement in effect with us at the time services are rendered. Participating vision care providers agree to accept the *negotiated rate* as payment for covered services.

**Plan** is the set of benefits described in this booklet and in the amendments to this booklet (if any). This plan is subject to the terms and conditions of the *policy* we have issued to the *group*. If changes are made to the plan, an amendment or revised booklet will be issued to the

*group* for distribution to each *employee* affected by the change. (The word "plan" here does not mean the same as "plan" as used in ERISA.)

**Policy** is the Group Policy we have issued to the *group*.

**Prior plan** is a plan sponsored by the *group* which was replaced by this *plan* within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

**Spouse** meets the *plan's* eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

**Vision care provider** is an ophthalmologist, optometrist or dispensing optician who is licensed to practice vision care, is rendering a service within the scope of the license and is providing a service for which benefits are specified in this booklet.

**We (us, our)** refers to Anthem Blue Cross Life and Health Insurance Company or Anthem Blue Cross (an affiliate of Anthem Blue Cross Life and Health).

**Year** or **calendar year** is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

**You (your)** refers to the *insured employee* and *insured family members* who are enrolled for benefits under this *plan*.

## FOR YOUR INFORMATION

### CLAIMS DISCLOSURE NOTICE REQUIRED BY ERISA

The certificate contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or Anthem Blue Cross Life and Health. In addition to this information, if this plan is subject to ERISA, ERISA applies some additional claim procedure rules. The additional rules required by ERISA are set forth below. To the extent that the ERISA claim procedure rules are more beneficial to you, they will apply in place of any similar claim procedure rules included in the certificate. This Claims Disclosure Notice Required By ERISA is not a part of your certificate.

**Urgent Care.** Anthem Blue Cross Life and Health must notify you, within 72-hours after they receive your request for benefits, that they have it and what they determine your benefits to be. If your request for benefits does not contain all the necessary information, they must notify you

within 24-hours after they get it and tell you what information is missing. Any notice to you by them will be orally, by telephone, or in writing by facsimile or other fast means. You have at least 48-hours to give them the additional information they need to process your request for benefits. You may give them the additional information they need orally, by telephone, or in writing by facsimile or other fast means.

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72-hours after Anthem Blue Cross Life and Health's receipt of the request for benefits, or 48 hours after receipt of all the information they need to process your request for benefits if the information is received within the time frame noted above. The notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision was based. You have 180-days to appeal their adverse benefit determination. You may appeal their decision orally, by telephone, or in writing by facsimile or other fast means. Within 72-hours after they receive your appeal, they must notify you of their decision, except as otherwise noted below. They will notify you orally, by telephone, or in writing by facsimile or other fast means. If your request for benefits is no longer considered urgent, it will be handled in the same manner as a Non-Urgent Care Pre-Service or Post-service appeal, depending upon the circumstances.

**Non-Urgent Care Pre-Service (when care has not yet been received).** Anthem Blue Cross Life and Health must notify you within 15-days after they receive your request for benefits that they have it and what they have determined your benefits to be. If they need more than 15-days to determine your benefits, due to reasons beyond their control, they must notify you within that 15-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 30-days to determine your benefits. If you do not properly submit all the necessary information for your request for benefits to them, they must notify you, within 5-days after they get it and tell you what information is missing. You have 45-days to provide them with the information they need to process your request for benefits. The time period during which Anthem Blue Cross Life and Health is waiting for receipt of the necessary information is not counted toward the time frame in which Anthem Blue Cross Life and Health must make the benefit determination.

If your request for benefits is denied in whole or in part, you will receive a written notice of the denial within the time frame stated above, or after Anthem Blue Cross Life and Health has all the information they need to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180-days to appeal their adverse benefit determination. Your appeal must be in writing. Within 30-days

after they receive your appeal, they must notify you of their decision about it. Their notice of their decision will be in writing.

### **Concurrent Care Decisions:**

- **Reduction of Benefits** – If, after approving a request for benefits in connection with your illness or injury, Anthem Blue Cross Life and Health decides to reduce or end the benefits they have approved for you, in whole or in part:
  - They must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal their decision before the reduction in benefits or end of benefits occurs. In their notice to you, Anthem Blue Cross Life and Health must explain their reason for reducing or ending your benefits and the plan provisions upon which the decision was made.
  - To keep the benefits you already have approved, you must successfully appeal Anthem Blue Cross Life and Health's decision to reduce or end those benefits. You must make your appeal to them at least 24-hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24-hours to the occurrence of the reduction or ending of benefits, your appeal may be treated as if you were appealing an urgent care denial of benefits (see the section "Urgent Care," above), depending upon the circumstances of your condition.
  - If Anthem Blue Cross Life and Health receives your appeal for benefits at least 24-hours prior to the occurrence of the reduction or ending of benefits, they must notify you of their decision regarding your appeal within 24-hours of their receipt of it. If Anthem Blue Cross Life and Health denies your appeal of their decision to reduce or end your benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see the section "Urgent Care," above).
- **Extension of Benefits** – If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved, you would like to request an extension of benefits for additional treatments:
  - You must make a request to Anthem Blue Cross Life and Health for the additional benefits at least 24-hours prior to the end of the

initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24-hours until the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an Urgent or Non-Urgent Care Pre-service request for benefits.

- If Anthem Blue Cross Life and Health receives your request for additional benefits at least 24-hours prior to the end of the initial course of treatment, previously approved for benefits, they must notify you of their decision regarding your request within 24-hours of their receipt of it if your request is for urgent care benefits. If Anthem Blue Cross Life and Health denies your request for additional benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may appeal the adverse benefit determination according to the rules for appeal for Urgent, Pre-Service or Post-Service adverse benefit determinations, depending upon the circumstances.

**Non - Urgent Care Post-Service (reimbursement for cost of vision care).** Anthem Blue Cross Life and Health must notify you, within 30-days after they receive your claim for benefits, that they have it and what they determine your benefits to be. If they need more than 30-days to determine your benefits, due to reasons beyond their control, they must notify you within that 30-day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 45-days to determine your benefits. If you do not submit all the necessary information for your claim to them, they must notify you, within 30-days after they get it and tell you what information is missing. You have 45-days to provide them with the information they need to process your claim. The time period during which Anthem Blue Cross Life and Health is waiting for receipt of the necessary information is not counted toward the time frame in which Anthem Blue Cross Life and Health must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above, or after Anthem Blue Cross Life and Health has all the information they need to process your claim, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180-days to appeal their decision. Your appeal must be in writing. Within 60-days after they receive your appeal, they must notify you of their decision about it. Their notice to you or their decision will be in writing.

**Note: You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits** with Anthem Blue Cross Life and Health and request a review of the denial. In connection with such a request:

- Documents pertinent to the administration of the Plan may be reviewed free of charge; and
- Issues outlining the basis of the appeal may be submitted.

You may have representation throughout the appeal and review procedure.

For the purposes of this provision, the meanings of the terms “Urgent Care,” “Non-Urgent Care Pre-Service,” and “Non - Urgent Care Post-Service,” used in this provision, have the meanings set forth by ERISA for a “claim involving urgent care,” “pre-service claim,” and “post-service claim,” respectively.



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