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University of Notre Dame Retirees

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Registered marks Blue Cross and Blue Shield Association.
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Health Certificate of Coverage

(herein called the “Certificate”)

Blue Traditional
Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204
Welcome to Anthem! This Certificate has been prepared by Us to help explain your coverage. Please refer to this Certificate whenever you require medical services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

The coverage described in this Certificate is subject in every respect to the provisions of the Group Contract pages issued to the Group. The Group Contract and this Certificate and any amendments or riders attached to the same, shall constitute the Group Contract under which Covered Services and supplies are provided by Us.

This Certificate should be read and re-read in its entirety. Since many of the provisions of this Certificate are interrelated, you should read the entire Certificate to get a full understanding of your coverage.

Many words used in the Certificate have special meanings. These words appear in capitals and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated.

This Certificate also contains Exclusions, so please be sure to read this Certificate carefully.

President

[Signature]
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**Health Certificate**
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Health Certificate
MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

- Recognizing and respecting you as a Member.
- Encouraging your open discussions with your health care professionals and Providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and Our Network Providers.
- Sharing Our expectations of you as a Member.

You have the right to:

- Participate with your health care professionals and Providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and Our policies.
- Receive information about Our organization and services, Our network of health care professionals and Providers, and your rights and responsibilities.
- Candidly discuss with your Physicians and Providers appropriate or Medically Necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization’s Members’ rights and responsibilities policies.
- Voice complaints or appeals about: Our organization, any benefit or coverage decisions We (or Our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your Physician(s) of the medical consequences.
- Participate in matters of the organization’s policy and operations.

You have the responsibility to:

- Choose a participating Primary Care Physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and Providers in developing mutually agreed upon treatment goals to the degree possible.

- Supply, to the extent possible, information that We and/or your health care professionals and Providers need in order to provide care.

- Follow the plans and instructions for care that you have agreed on with your health care professional and Provider.

- Tell your health care professional and Provider if you do not understand your treatment plan or what is expected of you.

- Follow all health benefit plan guidelines, provisions, policies and procedures.

- Let Our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.

- Provide Us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with Us.

3 SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Deductibles, Copayments and other limits when you receive Covered Services from a Provider. Please refer to the Covered Services section for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of the Benefit Booklet including any attachments or riders. **This Schedule of Benefits lists the Member's responsibility for Covered Services and supplies.** Benefits for Covered Services are based on the Maximum Allowable Amount. You are responsible for any balance due between the Provider's charge and the Maximum Allowable Amount, in addition to any Copayments, Deductibles, and non-Covered Charges.

<table>
<thead>
<tr>
<th>Benefit Period</th>
<th>Calendar Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEPENDENT AGE LIMIT</td>
<td>To the end of the Calendar Year in which the child attains age 24.</td>
</tr>
<tr>
<td>Pre-Existing Period</td>
<td></td>
</tr>
<tr>
<td>non-Late Enrollee</td>
<td>12 Months after your Enrollment Date</td>
</tr>
<tr>
<td>Late Enrollee</td>
<td>12 Months after your Enrollment Date</td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
</tr>
<tr>
<td>Per Member</td>
<td>$250</td>
</tr>
<tr>
<td>Per Family</td>
<td>$500</td>
</tr>
</tbody>
</table>

Note: When a Member incurs covered medical expenses during the last three months of a Benefit Period, which are applied against that year's Deductible, those expenses may be carried over and applied against the Deductible(s) for the next Benefit Period, but not the Out of Pocket.

<table>
<thead>
<tr>
<th>Out-of-Pocket Limit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Member</td>
<td>$2,500</td>
</tr>
<tr>
<td>Per Family</td>
<td>$5,000</td>
</tr>
</tbody>
</table>
Note: The Out-of-Pocket Limit includes all Deductibles and/or percentage Copayments you incur in a Benefit Period, except non-designated transplant facility Copayment amounts and flat dollar Copayment amounts for Prescription Drugs. After the Member and/or family Out-of-Pocket Limit is satisfied, no additional Copayments will be required for the Member and/or family for the remainder of the Benefit Period.

The Deductible applies to Covered Services with a percentage Copayment, except Prescription Drugs. Prescription Drugs are subject to separate Deductibles and Copayments.

**Lifetime Maximum for Prosthetic limbs**

(includes an orthotic custom fabricated Brace or support designed as a component for a Prosthetic limb)

Unlimited

**Note:** Prosthetic limbs (artificial leg or arm) or an Orthotic custom fabricated brace or support designed as a component for a Prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible and Copayment provisions otherwise applicable under the Plan. They are also subject to a separate lifetime maximum and do not apply to the Plan Lifetime Maximum.

**Lifetime Maximum for Human Organ and Tissue Transplants (See in Schedule below.)**

$1,000,000

**Lifetime Maximum for All Other Covered Services**

$1,000,000

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Copayment/Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>No Copayment up to the Maximum Allowable Amount</td>
</tr>
<tr>
<td>Limits:</td>
<td>$200 per Benefit Period $500 per Benefit Period (age 18 and over).</td>
</tr>
<tr>
<td>Note:</td>
<td>Any dollar limits on Preventive Care benefits will not apply to the following: routine screening mammography, prostate specific antigen (PSA) test, routine cytologic screening (pap test), colorectal cancer examination, and Diabetes Self Management Training which will be covered in full.</td>
</tr>
<tr>
<td>Physician Office Services</td>
<td>20% Copayment</td>
</tr>
<tr>
<td></td>
<td>For initial office visit services only. 20% Copayment for other Covered Services performed during an office visit.</td>
</tr>
<tr>
<td>Note:</td>
<td>When the only charge from a Physician home or office visit is for allergy injections, allergy serum, Diagnostic Services or Other Therapy Services, then any Copayments listed in dollar amounts are waived. Percentage Copayments are not waived.</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>20% Copayment</td>
</tr>
<tr>
<td>Maximum days per Benefit Period for Physical Medicine and Rehabilitation</td>
<td>60 days</td>
</tr>
</tbody>
</table>
### Outpatient Facility Services
20% Copayment

### Outpatient Therapy Services
20% Copayment

**NOTE:** If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Spinal Manipulation Service are performed during one Physician Home Visit, Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Spinal Manipulation Visit.

- **Maximum Visits per Benefit Period for:**
  - **Physical & Occupational Therapy:** Unlimited
  - When rendered in the home, the Home Care Services limits apply.
  - **Speech Therapy:** Unlimited
  - **Spinal Manipulations:** Unlimited

### Diagnostic Services
When rendered as Physician Office Services or Outpatient Services the Copayment is based on the setting where Covered Services are received. Other Diagnostic Services and/or tests, including services received at an independent lab, may not require a Copayment.

### Emergency Room
20% Copayment

**Note:** If admitted directly from the Emergency Room, the Emergency Room Copayment for that visit is waived.

### Urgent Care Facility
20% Copayment

### Ambulance Services
20% Copayment

### Home Care Services
20% Copayment

- **Maximum Visits per Benefit Period - includes Physical and Occupational Therapy rendered in the home.**

### Hospice Services
20% Copayment

### Human Organ and Tissue Transplant Services

**For cornea and kidney transplants, the transplant and tissue services benefits or requirements described below do not apply. These services are paid as Inpatient Services, Outpatient Services or Physician Office Services depending where the service is performed.**
Covered Transplant Benefit Period

Total of 365 continuous days beginning 1 day immediately prior to a Covered Transplant Procedure.

Transplant Maximum

Lifetime Maximum per Member for all Covered Transplant Services, under this Plan or any preceding or successive Human Organ and Tissue Transplant Benefit between the Group or Member and the Plan

$1,000,000 Participating and Non-Participating Transplant Provider services combined

Note:

Transportation/Lodging, Procurement, and Hospital Confinement are included in and accrue toward this Lifetime Maximum for all Transplant Services.

Transplants at a Non-Participating Transplant Facility do not count towards the Deductible or the Out-of-Pocket Maximum.

Non-Participating Transplant Facility

Transplant Services provided through a Non-Participating Transplant Facility, with respect to the type of Covered Transplant Procedure performed:

If the Covered Transplant Procedure is performed in a Non-Participating Transplant Facility, you will pay the lesser of 50% Copayment of billed charges, or 50% Copayment of the Maximum Allowable Amount shown below for the actual Covered Transplant Procedure. This amount will accrue to the $1,000,000 Lifetime Maximum.
**Transplant Services and Procedures**

With respect to the type of Covered Transplant Procedure performed:

<table>
<thead>
<tr>
<th>Participating Transplant Facility</th>
<th>Non-Participating Transplant Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Copayment up to the Maximum Allowable Amount</td>
<td>The lesser of 50% Copayment of billed charges or 50% Copayment of the Maximum Allowable Amount shown in the schedule below. If the Provider is also a Participating Provider for this Plan (for services other than Transplant Services and Procedures), then you will <strong>not</strong> be responsible for Covered Services which exceed our Maximum Allowable Amount. If the Provider is a Non-Participating Provider for this Plan, you <strong>will</strong> be responsible for Covered Services which exceed our Maximum Allowable Amount.</td>
</tr>
</tbody>
</table>

**Adult Procedures**

(Includes organ /tissue acquisition)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Charge Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Heart</td>
<td>$68,800</td>
</tr>
<tr>
<td>Adult Lung</td>
<td>$97,000</td>
</tr>
<tr>
<td>Adult Heart/Lung</td>
<td>$133,600</td>
</tr>
<tr>
<td>Adult Liver</td>
<td>$97,600</td>
</tr>
<tr>
<td>Adult Pancreas</td>
<td>$75,200</td>
</tr>
<tr>
<td>Kidney/Pancreas</td>
<td>$75,200</td>
</tr>
<tr>
<td>Adult Autologous Bone Marrow including High Dose Chemotherapy</td>
<td>$56,000</td>
</tr>
<tr>
<td>Adult <strong>Related</strong> Allogeneic Bone Marrow including High Dose Chemotherapy</td>
<td>$80,000</td>
</tr>
<tr>
<td>Adult <strong>Unrelated</strong> Allogeneic Bone Marrow including High Dose Chemotherapy</td>
<td>$88,000</td>
</tr>
</tbody>
</table>
**Pediatric Procedures**
(Includes organ /tissue acquisition)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Charge Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Autologous Bone Marrow including High Dose Chemotherapy</td>
<td>$66,400</td>
</tr>
<tr>
<td>Pediatric <strong>Related</strong> Allogeneic Bone Marrow including High Dose Chemotherapy</td>
<td>$93,600</td>
</tr>
<tr>
<td>Pediatric <strong>Unrelated</strong> Allogeneic Bone Marrow including High Dose Chemotherapy</td>
<td>$115,200</td>
</tr>
<tr>
<td>Pediatric Liver</td>
<td>$106,400</td>
</tr>
<tr>
<td>Pediatric Heart</td>
<td>$104,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transportation and Lodging</th>
<th>Participating Transplant Facility</th>
<th>Non-Participating Transplant Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Copayment up to the Maximum Allowable Amount</td>
<td>50% Copayment of Maximum Allowable Amount</td>
<td></td>
</tr>
</tbody>
</table>

Reasonable and necessary travel expenses related to a transplant at a Non-Participating Transplant Facility are covered at the Non-Participating Transplant Facility Copayment level.

**Medical Supplies, Durable Medical Equipment and Appliances**

20% Copayment

Note: Includes certain diabetic and asthmatic supplies when obtained from a Non-Participating Pharmacy.

**Maternity Services**

20% Copayment

Note: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity admission. That admission will be considered a separate Inpatient Service.

**Mental Health & Substance Abuse Services**

20% Copayment

Note: Coverage for the treatment of Mental Health and Substance Abuse conditions is provided in compliance with state and federal law.

---

4 **DEFINITIONS**

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

**Actively At Work** - Present and capable of carrying out the normal assigned job duties of the Group. Subscribers who are absent from work due to a health related disability, maternity leave or regularly scheduled vacation will be considered Actively At Work.

**Appeal** - A formal request by you or your...
representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

**Authorized Service** - A Covered Service which has been authorized in advance by Us to be paid.

**Benefit Period** - The period of time that We pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

**Certificate** - This summary of the terms of your benefits. It is attached to and is a part of the Group Contract and it is subject to the terms of the Group Contract.

**Copayment** - A specific dollar amount or percentage of Maximum Allowable Amount indicated in the Schedule of Benefits for which you are responsible for Covered Services. The Copayment does not apply towards any Deductible. Your flat dollar Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

**Covered Services** - Services, supplies or treatment as described in this Certificate which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Certificate.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under this Certificate is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this Certificate, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Certificate.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you.

**Covered Transplant Procedure** - Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblatie therapy.

**Custodial Care** - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

**Deductible** - The dollar amount of Covered Services listed in the Schedule of Benefits for which you are responsible before We start to pay for Covered Services subject to the Deductible each Benefit Period.

**Dependent** - A person of the Member’s family who is eligible for coverage under the Certificate as described in the Eligibility and Enrollment section.
**Designated Transplant Facility** - A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions for transplants to you for this Certificate. A Hospital may be a Designated Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

**Diagnostic Service** - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition or a test performed as a Medically Necessary preventive care screening for an asymptomatic patient. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the Covered Services section.

**Domiciliary Care** - Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

**Effective Date** - The date when your coverage begins under this Certificate. You must be Actively At Work on your Effective Date. If you are not Actively At Work on your scheduled Effective Date, your Effective Date will be the date you become Actively At Work. A Dependent's coverage begins on the Effective Date of the sponsoring Subscriber.

**Eligible Person** - A person who satisfies the Group's eligibility requirements and is entitled to apply to be a Subscriber.

**Emergency** - An accidental traumatic bodily injury or other medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- place an individual's health in serious jeopardy;
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

**Emergency Care** - Covered Services that are furnished by a Provider within the scope of the Provider's license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

**Enrollment Date** - The first day of coverage or, if there is a waiting period, the first day of the waiting period (typically the date employment begins).

**Expedited Review** - The expedited handling of a Grievance or Appeal concerning Our denial of certification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

**Experimental/Investigative** - Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine in Our sole discretion to be Experimental/Investigative. We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
• is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

• is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

• is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

• the scientific evidence is conclusory concerning the effect of the service on health outcomes;

• the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

• the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and

• the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by Us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

• published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

• evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

• documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

• documents of an IRB or other similar body performing substantially the same function; or

• consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

• medical records; or

• the opinions of consulting Providers and other experts in the field.

We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

External Grievance - Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an

Health Certificate
independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Certificate.

**Family Coverage** - Coverage for the Subscriber and eligible Dependents.

**Grievance** - Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;
- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan or the Group and the Plan.

**Group** - The employer or other entity that has entered into a Group Contract with the Plan.

**Group Contract (or Contract)** - The contract between the Plan and the Group. It includes this Certificate, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

**Identification Card** - A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

**Inpatient** - A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

**Late Enrollee** - An individual whose enrollment under the Plan is a Late Enrollment.

**Late Enrollment** - Enrollment other than on:

- the earliest date on which coverage can become effective under this Certificate; or
- a Special Enrollment date.

**Lifetime Maximum** - The maximum dollar amount We will pay for Covered Services during your lifetime.

**Maximum Allowable Amount (Maximum Allowed Amount)** - The maximum amount that We will allow for Covered Services You receive. For more information, see the “Claims Payment” section.

**Medically Necessary or Medical Necessity** - An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by Us to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of
hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);

- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost);
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an exclusion under this Certificate.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary.

**Medicare** - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

**Member** - A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called “you” and “your”.

**Mental Health Conditions and Substance Abuse** - Conditions identified as mental disorders in the most current version of the International Classification of Diseases (ICD) Manual, in the chapter titled “Mental Disorders”.

- Mental Health is a condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical causes.
- Substance Abuse is a condition brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost.

In determining whether or not a particular condition is a Mental Health Condition, the Plan may refer to the most current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD) Manual.

**New FDA Approved Drug Product or Technology** - The first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

**Non-Designated Transplant Facility** - Any Hospital which has not contracted with the organization engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Designated Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

**Out of Pocket Limit** - A specified dollar amount of expense incurred by a Member and/or family for Covered Services in a Benefit Period as listed on the Schedule of Benefits. When the Out of Pocket Limit is reached for a Member and/or family, then no additional Deductibles and Copayments are required for that person and/or
family unless otherwise specified in this Certificate and/or the Schedule of Benefits.

**Outpatient** - A Member who receives services or supplies while not an Inpatient.

**Participating Specialty Pharmacy** – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Participating Provider.

**Plan (We, Us, Our)** - Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Certificate.

**Precertification or Preauthorization** - A procedure which requires that an approval be obtained from Us before incurring expenses for certain Covered Services. When care is evaluated, both the Medical Necessity for admissions and appropriate length of stay; will be determined.

**Pre-Existing Condition** - A condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within 6 Months of the period ending on your Enrollment Date. Pregnancy is not considered a Pre-Existing Condition. Genetic information may not be used as a condition in the absence of a diagnosis.

**Premium** - The periodic charges which the Member or the Group must pay the Plan to maintain coverage.

**Prior Authorization** - The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

**Provider** - A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities:

- **Alternative Care Facility** - A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
  1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
  2. Surgery;
  3. Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A Provider that:
  1. is licensed as such, where required;
  2. is equipped mainly to do Surgery;
  3. has the services of a Physician and a Registered Nurse (R.N.) at all times when a patient is present;
  4. is not an office maintained by a Physician for the general practice of medicine or dentistry; and
  5. is equipped and ready to initiate emergency procedures with personnel who are certified in Advanced Cardiac Lifesaving Skills.

- **Birthing Center** - A Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
  1. constituted, licensed, and operated as set forth in the laws that apply;
  2. equipped to provide low-risk maternity care;
  3. adequately staffed with qualified personnel who:
      a. provide care at childbirth;
      b. are practicing within the scope of their training and experience; and
      c. are licensed if required; and
4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state’s appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:
  1. provides room and board and nursing care for its patients;
  2. has a staff with one or more Physicians available at all times;
  3. provides 24 hour nursing service;
  4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
  5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. nursing care;
2. rest care;
3. convalescent care;
4. care of the aged;
5. Custodial Care;
6. educational care;
7. treatment of alcohol abuse; or
8. treatment of drug abuse.

- **Pharmacy** - An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician’s order.

- **Physician** -
  1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or
  2. any other legally licensed practitioner of the healing arts rendering services which are:
     a. covered by the Plan;
     b. required by law to be covered when rendered by such practitioner; and
     c. within the scope of his or her license.

Physician does not include:

1. the Member; or
2. the Member’s spouse, parent, child, sister, brother, or in-law.

- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:

  1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
2. provides care supervised by a Physician;
3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
5. is not a rest, educational, or Custodial Provider or similar place.

- **Urgent Care Center** - A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

- **Recovery** - A Recovery is money you receive from another, their insurer or from any “Uninsured Motorist”, “Underinsured Motorist”, “Medical-Payments”, “No-Fault”, or “Personal Injury Protection” or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

- **Skilled Care** - Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

**Stabilize** - The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you; or
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital’s Inpatient setting.

- **Subcontractor** - The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs and mental health/behavioral health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

- **Subscriber** - An eligible employee or retired employee or member of the Group whose coverage is in effect and whose name appears on the Identification Card issued by Us.

- **Therapy Services** - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the Covered Services section.

5. **ELIGIBILITY AND ENROLLMENT**

Coverage provided under this Certificate is made available to you because of your employment with or membership with or retirement from the Group.

In order for you to participate in the Group’s benefit plan, certain requirements must be satisfied. These requirements may include probationary or waiting periods, and Actively at Work standards. The specific time periods and other standards for participation in the Group’s benefit plan are determined by the Group, or state and/or federal law, and approved by Us. Eligibility requirements are described in general terms below.

**For more specific eligibility**
Eligibility and Enrollment

You should see your Human Resources or benefits department.

Eligibility

Unless We and the Group agree otherwise and notify you accordingly, the following eligibility rules apply:

Subscriber

To be eligible to enroll as a Subscriber, you must be:

- a Subscriber of the Group who is entitled to participate in the benefit plan arranged by the Group, and who has satisfied any probationary or waiting period established by the Group and other eligibility criteria established by the Group; and/or

- a Subscriber of the Group who is entitled to coverage under a trust agreement or employment contract.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group and be:

- The Subscriber’s spouse as recognized under the laws of the state where the Subscriber lives.

- The following children, regardless of the level of support by the Subscriber: the Subscriber’s natural children, newborn and legally adopted children, or children who the Group has determined are covered under a “Qualified Medical Child Support Order” as defined by ERISA or any applicable state law.

- The following children, if the Subscriber provides more than fifty percent (50%) of the child’s total support: stepchildren, children for whom the Subscriber or the Subscriber’s spouse is a legal guardian, or the Subscriber’s or the Subscriber’s spouse’s grandchildren or other blood relatives.

All enrolled eligible, children will continue to be covered until the age limit listed in the Schedule of Benefits.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves due to mental retardation or physical or mental handicap. The Dependent’s disability must start before the end of the period they would become ineligible for coverage. The Plan must certify the Dependent’s eligibility. The Plan must be informed of the Dependent’s eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must notify Us if the Dependent’s status changes and they are no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child’s coverage.

To obtain coverage for children, We may require that the Subscriber complete a “Dependency Affidavit” and provide Us with a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under this Certificate.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under the Plan unless required by the laws of this state.

Coverage Effective Dates and enrollment requirements are described in the Group Contract.

College Student Medical Leave

The Plan will extend coverage for up to one year when a college student otherwise would lose eligibility, if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent’s termination of employment or the child’s age exceeding the Plan’s limit.
Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status). The Plan must receive written certification from the child’s Physician confirming the serious illness or injury and the Medical Necessity of the leave or change in status.

Coverage continues even if the plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

Enrollment

Initial Enrollment

During the initial Enrollment period, eligible Subscribers of the Group shall be entitled to apply for coverage for themselves and their eligible Dependents, who are listed on the enrollment form provided by Us.

Newly Eligible Persons

Any person who becomes newly eligible after the initial Enrollment period (e.g., new spouse, newly hired or newly transferred Subscriber), is eligible for coverage effective on the first date eligible only if all of the following conditions are met:

- The enrollment form must be received by the Plan within thirty-one (31) days of becoming eligible; and
- Timely payment of the applicable enrollment fees.

This section does not apply to newborn and adopted children. See the Newborn and Adopted Child Coverage provision.

Newborn and Adopted Child Coverage

Any Dependent child born while the Subscriber or Member's spouse is eligible for coverage will be covered from birth for a period of 31 days. Any Dependent child adopted while the Subscriber or the Member's spouse is eligible for coverage will be covered from the date of placement for purposes of adoption for a period of 31 days.

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you, and will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

To continue coverage beyond the 31 day period after the child’s birth or adoption you must notify Us by submitting a Change of Status Form to add the child under the Subscriber's Certificate. The Change of Status Form must be submitted within 31 days after the birth or placement of the child. If timely notice is given, an additional Premium for the coverage of the newborn child or adopted child will not be charged for the duration of the notice period. However, if timely notice is not given, We may charge an additional Premium from the child’s date of birth or placement for adoption.

If the child is not enrolled within 31 days of the date of birth or placement for adoption, coverage will cease.

Newborn and Adopted Child Coverage will be for illness and injury, including care or treatment of:

- congenital defects;
- birth abnormalities; or
- premature birth.

Newborn and adopted children are exempt from the Pre-Existing exclusion in this Certificate if they are covered under the Plan within thirty-one (31) days of the date of birth or placement for adoption.
Adding a Child due to Legal Guardianship

If a Subscriber or the Subscriber’s spouse becomes the legal guardian for a child, an application must be submitted within 31 days of the date legal guardianship is approved by the court or the child will be treated as a Late Enrollee. Coverage will be effective on the date the court approves legal guardianship if We receive an application within 31 days of that qualifying event.

Qualified Medical Child Support Order/Court Ordered Health Coverage

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child under this Certificate, We will permit your child to enroll at any time without regard to any open enrollment limits and shall provide the benefits of this Certificate in accordance with the applicable requirements of such order. A child’s coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under this Certificate will be paid, at Our discretion, to the child or the child’s custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Special Enrollment

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Plan, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If We receive an application to add your Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, that person is only eligible for coverage as a Late Enrollee. Application forms are available from the Plan.

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee’s or Dependent’s Medicaid or Children’s Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program) under Medicaid or CHIP.

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If We receive an application to add your Dependent or an Eligible Person and Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, that person is only eligible for coverage as a Late Enrollee.

Application forms are available from the Plan.

Late Enrollment

An eligible Subscriber or Dependent who did not request enrollment for coverage with the Plan during the initial enrollment period, as a newly eligible person, or a special enrollment period during which the individual was entitled to enroll under the Plan may apply for coverage at any time during the year as a Late Enrollee.

The Late Enrollee may be subject to the Pre-Existing Condition limitation applicable to Late Enrollees as specified in the Schedule of Benefits.

Continuous Coverage

If you were covered by the Group’s prior carrier or plan immediately prior to the Group’s enrollment with Anthem Blue Cross Blue Shield, with no break in coverage, then you will receive credit for any accrued Deductible and, if applicable and
approved by Us, Out of Pocket amounts under that other plan. This does not apply to persons who were not covered by the prior carrier or plan on the day before the Group’s coverage with Us began, or to persons who join the Group later.

If your Group moves from one Anthem Blue Cross Blue Shield plan to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately prior to enrolling in this product with no break in coverage, then you may receive credit for any accrued Deductible and Out of Pocket amounts, if applicable and approved by Us. Any maximums, including the Lifetime Maximum, when applicable, will be carried over and charged against the maximums and/or Lifetime Maximum under this Certificate.

If your Group offers more than one Anthem product, and you change from one Anthem product to another with no break in coverage, you will receive credit for any accrued Deductible and, if applicable, Out of Pocket amounts and any maximums, including the Lifetime Maximum will be carried over and charged against maximums, including the Lifetime Maximum.

If your Group offers coverage through other products or carriers in addition to Anthem’s, and you change products or carriers to enroll in this Anthem product with no break in coverage, you will receive credit for any accrued Deductible, Out of Pocket, and any maximums, including Lifetime Maximum amounts.

**This Section Does Not Apply To You If:**

- Change from an individual Anthem Blue Cross Blue Shield policy to a group Anthem Blue Cross Blue Shield plan;

- Change employers and both have Anthem Blue Cross Blue Shield coverage; or

- Are a new Member of the Group who joins the Group after the Group’s initial enrollment with Us. Such new Members will receive credit from their prior carrier as described in the "Portability" section.

**Portability**

Any Pre-Existing Condition waiting period will be reduced by the aggregate of the periods of prior creditable coverage applicable to you as of your Enrollment Date under this Plan. Creditable coverage is prior coverage you had from: a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children’s health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan. You have the opportunity to prove that you have prior creditable coverage and We will assist you in obtaining that information if required.

**Delivery of Documents**

We will provide the Group with a Plan Identification Card for each Member and a Certificate for each Subscriber.

**Notice of Ineligibility**

You must notify Us of any changes which will affect your Dependent’s eligibility for services or benefits under this Certificate.

**Notice of Changes**

The Subscriber is responsible to notify the Group of any changes which will affect his or her eligibility or that of Dependents for services or benefits under this Certificate. The Plan must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another health plan or Medicare. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of payments from the Group for persons no longer eligible for services will not obligate Us to pay for such services.
Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 31 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications by the Group must be in writing and on approved forms. Such notifications must include all information reasonably required to effect the necessary changes.

A Member's coverage terminates on the date such Member ceases to be in a class of Members eligible for coverage. The Plan has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's coverage.

Effective Date of Coverage

For information on your specific Effective Date of coverage under this Certificate, you should see your Human Resources or benefits department or contact Us.

6 TERMINATION, CONTINUATION AND CONVERSION

Termination

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your Group's agreement with Us and your specific circumstances, such as whether premium has been paid in full:

- If you terminate your coverage, termination will generally be effective on the last day of the billing period in which We received your notice of termination.

- Subject to any applicable continuation or conversion requirements, if you cease to meet eligibility requirements as outlined in this Certificate, your coverage generally will terminate on the last day of the billing period. The Group and/or you must notify Us immediately if you cease to meet the eligibility requirements. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

- If you engage in fraudulent conduct or furnish Us fraudulent or misleading material information relating to claims or application for coverage, then We may terminate your coverage. Termination is generally effective 31 days after Our notice of termination is mailed. You are responsible to pay Us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services. We will also terminate your Dependent's coverage, generally effective on the date your coverage was terminated. We will notify the Group in the event We terminate your and your Dependent's coverage.

- A Dependent's coverage will generally terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent.

- If coverage is through an association, coverage will generally terminate on the date membership in the association ends.

- If you elect coverage under another carrier's health benefit plan or under any other non-Anthem plan which is offered by, through, or in connection with the Group as an option instead of this Plan, then coverage for you and your Dependents will generally terminate at the end of the billing period for which premium has been paid, subject to the consent of the Group. The Group agrees to immediately notify Us that you have elected coverage elsewhere.
• If you fail to pay or fail to make satisfactory arrangements to pay any amount due to Us or Network Providers (including the failure to pay required Deductibles and/or Copayments), We may terminate your coverage and may also terminate the coverage of all your Dependents, generally effective immediately upon Our written notice to the Group.

• If you permit the use of your or any other Member’s Plan Identification Card by any other person; use another person’s card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice to the Group. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for the Maximum Allowable Amount for services received through such misuse.

Reinstatement

You will not be reinstated automatically if coverage is terminated. Re-application is necessary, unless termination resulted from inadvertent clerical error. No additions or terminations of membership will be processed during the time your or the Group’s request for reinstatement is being considered by Us. Your coverage shall not be adversely affected due to the Group’s clerical error. However, the Group is liable to Us if We incur financial loss as a result of Group’s clerical error.

Certification of Coverage

If your coverage under this Plan is terminated, you and your covered Dependents will receive a certification that shows your period of coverage under this health benefit plan. You may need to furnish the certification if you become eligible under another group health plan. You may also need the certification to buy, for yourself or your family, an individual policy that does not exclude coverage for medical conditions that were present before your enrollment. You and your Dependents may request a certification within 24 months of losing coverage under this health benefit plan. If you have any questions, contact the customer service telephone number listed on the back of your Identification Card.

Conversion

Conversion coverage is not available under this Certificate.

Federal Continuation of Coverage (COBRA)

The following applies if you are covered under a Group which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group’s health plan. It can also become available to other Members of your family, who are covered under the Group’s health plan, when they would otherwise lose their health coverage. For additional information about your rights and obligations under federal law under the coverage provided by the Group’s health plan, you should contact the Group.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Group’s health plan when coverage would otherwise end because of a life event known as a ”qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a ”qualified beneficiary.” You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Group’s health plan is lost because of the qualifying event. Under the Group’s health plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Group for Premium payment requirements.
If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group's health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group's health plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Group's health plan because any of the following qualifying events happens:

- The parent-Subscriber dies;
- The parent-Subscriber's hours of employment are reduced;
- The parent-Subscriber's employment ends for any reason other than his or her gross misconduct;
- The parent-Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both); or
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Group's health plan as a "Dependent child."

If Your Group Offers Retirement Coverage

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Group, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Group's health plan, the retired Subscriber will become a qualified beneficiary with respect to the bankruptcy. The retired Subscriber's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under Group's health plan.

When is COBRA Coverage Available

COBRA continuation coverage will be offered to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), then you must notify the Group of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided

Once the Group receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Subscribers may elect COBRA continuation coverage on behalf of
their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the Subscriber, the Subscriber’s becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child’s losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber’s hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a covered Subscriber becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

**Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Group’s health plan is determined by the Social Security Administration to be disabled and you notify the Group in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

**Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Group. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Subscriber or former Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Group’s health plan had the first qualifying event not occurred.

**If You Have Questions**

Questions concerning your Group’s health plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

**Conversion**

A conversion option is not available with this program.
Public Employee Continuation of Coverage

If you are covered through a Group that is a local unit public employer, as defined by Indiana law, you may be eligible for continuation of coverage under this Plan beyond the date your coverage would otherwise end. Please see your Group’s Human Resources or benefits department for further information concerning your eligibility for continuation of coverage.

Family and Medical Leave Act of 1993

A Subscriber who is taking a period of leave under the Family and Medical Leave Act of 1993 (the Act) will retain eligibility for coverage during this period. The Subscriber and his or her Dependents shall not be considered ineligible due to the Subscriber not being Actively At Work.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without medical underwriting and without imposition of an additional waiting period for Pre-Existing Conditions. To obtain coverage for a Subscriber upon return from leave under the Act, the Group must provide the Plan with evidence satisfactory to Us of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under this Certificate in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Certificate by notifying your employer in advance and payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active employee contribution, if any, for continuation of health coverage.

If continuation is elected under this provision, the maximum period of health coverage under this Certificate shall be the lesser of:

- The 18-month period (24 months if continuation is elected on or after 12/10/2004) beginning on the first date of your absence from work; or
- The day after the date on which you fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under this Certificate. No exclusions or waiting period may be imposed on you or your eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.
HOW TO OBTAIN COVERED SERVICES

We have final authority to determine the Medically Necessity of Covered Services. We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other Facility. This decision is made upon review of your condition and treatment.

Work with Physicians or other professional Providers, Hospitals and other facility Providers to:

- obtain any Precertification which is required; and
- file claims.

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Certificate does not give anyone any claim, right, or cause of action against the Plan based on what a Provider of health care, services or supplies, does or does not do.

Identification Card

When you receive care from a Provider, you must show your Identification Card. Possession of an Identification Card confers no right to services or other benefits under this Certificate. To be entitled to such services or benefits you must be a Member on whose behalf all applicable Premiums under this Certificate have been paid. If you receive services or other benefits to which you are not then entitled under the provisions of this Certificate you will be responsible for the actual cost of such services or benefits.

HEALTH CARE MANAGEMENT

Health Care Management is included in your health care benefits to encourage you to seek quality medical care on the most cost-effective and appropriate basis.

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Members by reviewing the use of appropriate procedures, setting (place of service), and resources through Case Management and through Precertification review requirements which may be conducted either prospectively (Prospective review), concurrently (Concurrent review), or retrospectively (Retrospective review).

If you have any questions regarding Health Care Management or to determine which services require Precertification, call the Precertification telephone number on the back of your Identification Card or refer to Our website, www.anthem.com.

Members are entitled to receive upon request and free of charge reasonable access to and copies of documents, records, and other information relevant to the Member's Precertification request.

Your right to benefits for Covered Services provided under this Certificate is subject to certain policies, guidelines and limitations, including, but not limited to, Our Clinical Coverage Guidelines, medical policy and Health Care Management features listed in this section.

Clinical Coverage Guidelines

Our clinical coverage guidelines such as medical policy, preventive care clinical coverage guidelines, Precertification review guidelines, Concurrent review guidelines, and Retrospective review guidelines, reflect the standards of practice and medical interventions identified as reflecting appropriate medical practice. The purpose of Clinical Coverage Guidelines is to assist in the
interpretation of Medical Necessity. However, the Certificate and Group Contract take precedence over the clinical coverage guidelines. Medical technology and standards of care are constantly changing and We reserve the right to review and update the clinical coverage guidelines periodically.

Precertification

NOTICE: Precertification or prior authorization does NOT guarantee coverage for or payment of the service or procedure reviewed. It is a confirmation of Medical Necessity only.

Precertification is a Health Care Management feature which requires that an approval be obtained from Us before incurring expenses for certain Covered Services. Our procedures and timeframes for making decisions for Precertification requests differ depending on when the request is received and the type of service that is the subject of the Precertification request.

Urgent Review means a review for medical care or treatment, that in the opinion of the treating Provider or any Physician with knowledge of the Member’s medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent lay person’s judgment, or, in the opinion of a Physician with knowledge of the Member’s medical condition, would subject the Member to severe pain that cannot be adequately managed without such care or treatment. Applying the prudent layperson standard, We may determine that an Urgent Review should be conducted. Concurrent reviews of continued Hospital stays will always be considered urgent.

When care is evaluated, both Medical Necessity and appropriate length of stay for Inpatient admissions will be determined. Medical Necessity includes a review of both the services and the setting. For certain services you will be required to use the Provider designated by Our Health Care Management staff. The care will be covered according to your benefits for the number of days approved unless our Concurrent review determines that the number of days should be revised. If a request is denied, the Provider may request a reconsideration. Our Physician reviewer will be available by telephone for the reconsideration within one business day of the request. An expedited reconsideration may be requested when the Member’s health requires an earlier decision.

Most Providers know which services require Precertification and will obtain any required Precertification. Most Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. Generally, the ordering Provider, facility or attending Physician will call to request a Precertification review (“requesting Provider”). We will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific Precertification request. The authorized representative can be anyone who is 18 years or older. For Urgent Reviews as defined above, the requesting Provider will be presumed to be acting as your authorized representative. For more information on Our process for designating an authorized representative, call the Precertification telephone number on the back of your Identification Card.

You are responsible for obtaining Precertification for certain services you obtain:

• from a Non-Participating Provider; or
• from a Participating Provider through the local Blue Cross and Blue Shield Plan if you are traveling or you live outside of the Service Area.

When it is your responsibility to obtain Precertification, you should either:

• verify that the Non-Participating or Blue Card Provider obtains the required Precertification; or
• obtain the required Precertification yourself.
If you or your Non-Participating or Blue Card Provider do not obtain the required Precertification, a Retrospective review will be done to determine if your care was Medically Necessary. If We determine the services you receive are not Medically Necessary under your Plan and you received your care from a Blue Card Provider or a Provider that does not have a participation agreement with Us, you will be financially responsible for the services.

For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a participation agreement with Us or is a Blue Card Provider, you will be financially responsible for any care We determine is not Medically Necessary.

For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Precertification Procedures

**Prospective review** means a review of a request for Precertification that is conducted prior to a Member’s Hospital admission or course of treatment. For Prospective reviews, a decision will be made and telephone notice of the decision will be provided to the requesting Provider, as soon as possible, taking into account the medical circumstances, but not later than two business days from the time the request is received by Us. For Urgent Reviews, telephone notice will be provided to the requesting Provider as soon as possible taking into account the medical urgency of the situation, but not later than two calendar days from the time the request is received by Us. If additional information is needed to certify benefits for services, We will notify the requesting Provider by telephone and send written notification to you or your authorized representative and the requesting Provider of the specific information necessary to complete the review as soon as possible, but not later than two business days after receipt of the request. For Urgent Reviews we will notify the requesting Provider by telephone of the specific information necessary to complete the review within 24 hours after receipt of the request by Us. Written notice will be sent following the request by telephone.

The requested information must be provided to Us within 45 calendar days from receipt of Our request. Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day. For Urgent Reviews, the requested information must be provided within 48 hours after Our request for specific information.

A decision will be made and telephone notice of the decision will be provided to the requesting Provider as soon as possible, but not later than two business days (two calendar days for Urgent Reviews) after Our receipt of the requested information.

If a response to Our request for specific information is not received or is not complete, a decision will be made based upon the information in Our possession and telephone notice of the decision will be provided to the requesting Provider not later than two business days (two calendar days for Urgent Reviews) after the expiration of the period to submit the requested information.

Written notice of Prospective review decisions will be provided to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

**Concurrent Review**

**Concurrent review** means a review of a request for Precertification that is conducted during a Member’s Inpatient Hospital stay or course of treatment. As a result of Concurrent review, additional benefits may be approved for care
which exceeds the benefit(s) originally authorized by Our Health Care Management staff.

If a request for Concurrent review is received within 24 hours prior to the expiration of the end of the approved care, and it qualifies for Urgent Review, a decision will be made and telephone notice of the decision will be provided to the requesting Provider as soon as possible, taking into account the medical urgency of the situation, but not later than 24 hours from the time the request is received by Us. If the request is not received within 24 hours prior to the end of the approved care, the decision will be made and telephone notice of the decision will be provided to the requesting Provider within two calendar days from the time the request is received by Us. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

For Concurrent reviews that do not qualify for Urgent Review, the decision will be made and telephone notice will be provided to the requesting Provider and written notice of the decision will be sent to you or your authorized representative and the Provider(s) within two business days from the time the request is received by Us.

If additional information is needed to certify benefits for services for a Concurrent review that does not qualify for Urgent Review, We will notify the requesting Provider by telephone and will send written notice to you or your authorized representative and the requesting Provider of the specific information necessary to complete the review within two business days after receipt of the request.

You or your authorized representative and the requesting Provider have 45 calendar days from receipt of Our request to provide the information to Us. Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day. A decision will be made and telephone notice of the decision will be provided to the requesting Provider and written notice of the decision will be sent to your or your authorized representative and the Provider(s) not later than two business days after expiration of the period to submit the requested information.

We will not reduce or terminate a previously approved on-going course of treatment until you or your authorized representative receive telephone notice of Our decision and have an opportunity to Appeal the decision and receive notice of the Appeal decision.

Retrospective Review

Retrospective review means a Medical Necessity review that is conducted after health care services have been provided to a Member. If Precertification is required but not obtained prior to the service being rendered, We will conduct a Retrospective review. Further, if a service is subject to a Clinical Coverage Guideline, but Precertification is not required for that service, We may conduct a Retrospective Review. Retrospective review may be completed before a claim is submitted (pre-claim) or after a claim is submitted (post-claim). It does not include a post-claim review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

For pre-claim Retrospective review, a decision will be made within two business days from the time the request is received by Us. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within two business days from the time the request is received by Us.

If additional information is needed to certify benefits for services, We will notify you or your authorized representative and the requesting Provider in writing, of the specific information necessary to complete the review, within two business days after receipt of the request.

You or your authorized representative and the requesting Provider have 45 calendar days from receipt of Our request to provide the information to Us. Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day. A decision will be made and telephone notice of the decision will be provided to the requesting Provider and written notice of the decision will be sent to your or your authorized representative and the Provider(s) not later than two business days after expiration of the period to submit the requested information.
specific information is not received or is not complete, a decision will be made based upon the information in Our possession not later than two business days after expiration of the period to submit the requested information.

For post-claim Retrospective Review, a decision will be made within 30 calendar days from the time the claim is received by Us. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within five business days of the date the decision is rendered, but not later than 30 calendar days from the time We receive the claim.

If additional information is needed to certify benefits for services, We will notify you or your authorized representative and the requesting Provider in writing of the specific information necessary to complete the review within 30 calendar days after receipt of the claim.

You or your authorized representative and the requesting Provider(s) have a reasonable amount of time taking into account the circumstances, but not less than 45 calendar days from the date of Our request to provide the additional information to Us. A decision will be made within 15 calendar days from the time the requested information is received by Us. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within five business days of the date the decision is rendered, but not later than 15 calendar days of receiving the requested information.

Case Management (includes Discharge Planning)

Case Management is a Health Care Management feature designed to promote the most appropriate and cost effective care setting. This feature allows Us to customize your benefits by approving otherwise non-Covered Services or arranging an earlier discharge from an Inpatient setting for a patient whose care could be safely rendered in an alternate care setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by Our Health Care Management staff. In managing your care, We have the right to authorize substitution of Outpatient Services or services in your home to the extent that benefits are still available for Inpatient Services.

9 COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Certificate, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Certificate and obtain any required Prior Authorization or Precertification. Contact your Provider to be sure that Prior Authorization/Precertification has been obtained.

We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and medical policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Certificate. Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Copayment, Deductible, Benefit Period maximum, or Lifetime Maximum in this
Preventive Care Services

Preventive Care benefits may vary based on the age, sex, and personal history of the individual, and as determined appropriate by Our Clinical Coverage Guidelines. Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Some examples of Preventive Care Covered Services are:

- Routine or periodic exams, including school enrollment physical exams. (Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not Covered Services.) Examinations include, but are not limited to:
  1. Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines. Child health supervision services includes, but is not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.
  2. Adult routine physical examinations.
  3. Pelvic examinations.
  4. Routine EKG, Chest X-rays, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis.
  5. Annual dilated eye examination for diabetic retinopathy.

- Immunizations (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). For adults, we follow the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians. These include, but are not limited to:
  1. Hepatitis A vaccine
  2. Hepatitis B vaccine
  3. Hemophilus influenza b vaccine (Hib)
  4. Influenza virus vaccine
  5. Rabies vaccine
  6. Diphtheria, Tetanus, Pertussis vaccine
  7. Mumps virus vaccine
  8. Measles virus vaccine
  9. Rubella virus vaccine
  10. Poliovirus vaccine

- Screening examinations:
  1. Routine vision screening for disease or abnormalities, including but not limited to diseases such as glaucoma, strabismus, amblyopia, cataracts;
  2. Routine hearing screening.
  3. Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered;
4. Routine cytologic and chlamydia screening (including pap test);
5. Routine bone density testing for women;
6. Routine prostate specific antigen testing;
7. Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

**Diabetes Self Management Training**

Diabetes self management training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

**Physician Office Services**

Office Services include care in a Physician’s office that is not related to Maternity, except as specified. Refer to the section entitled **Maternity Services** for services covered by the Plan. For **Emergency Accident or Medical Care refer to the Emergency Care and Urgent Care** section.

**Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits include injections including allergy injections. When an allergy injection or allergy serum is the only charge from a Physician’s office no Copayment is required if stated in dollars. Any Copayments stated as percentages are not waived.

**Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.

**Surgery** and Surgical services including anesthesia and supplies. The surgical fee includes normal post-operative care.

**Therapy Services** for Physical Medicine Therapies and Other Therapies when rendered in the office of a Physician or other professional Provider.

**Inpatient Services**

Inpatient Services do not include care related to Maternity, except as specified. Refer to the sections entitled **Maternity Services** for services covered by the Plan. Inpatient Services include:

- charges from a Hospital or other Provider for room, board and general nursing services;
- ancillary services; and
- professional services from a Physician while an Inpatient.

**Room, Board, and General Nursing Services**

- a room with two or more beds;
- a private room. The private room allowance is the Hospital’s average semi-private room rate unless it is Medically Necessary that you occupy a private room for isolation and no isolation facilities are available.
- a room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.
Ancillary Services

- operating, delivery and treatment rooms and equipment;

- prescribed drugs;

- anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider;

- medical and surgical dressings, supplies, casts and splints;

- Diagnostic Services; and

- Therapy Services.

Professional Services

- Medical care visits limited to one visit per day by any one Physician.

- Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time.

- Concurrent care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.

- Consultation which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules are excluded.

- Surgery and the administration of general anesthesia.

- Newborn exam. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment stated in dollars per admission in the Schedule of Benefits is waived for the second admission. Copayments stated as a percentage are not waived.

Outpatient Services

Outpatient Services include both facility and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. Outpatient Services do not include care that is related to Maternity, except as otherwise specified. Refer to the section titled Maternity Services for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copayment is required if stated in dollars. Any Copayment stated as a percentage will still apply to these services.

For Emergency Care refer to the Emergency Care and Urgent Care section.

Cancer Clinical Trials

Benefits are available for services for routine patient care rendered as part of a cancer clinical trial if the services are otherwise Covered Services under this Certificate and the clinical trial is performed:

- using a particular care method to prevent, diagnose, or treat a cancer for which:

  1. there is no clearly superior, non-investigational alternative care method; and

  2. available clinical or preclinical data provides a reasonable basis from which
to believe that the care method used in the research study is at least as effective as any non-investigational alternative care method; and

- in a facility where personnel providing the care method to be followed in the research study have:

  1. received training in providing the care method;
  2. expertise in providing the type of care required for the research study; and
  3. experience providing the type of care required for the research study to a sufficient volume of patients to maintain expertise; and

- to scientifically determine the best care method to prevent, diagnose, or treat the cancer; and

- the trial is approved or funded by one of the following:

  1. The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services;
  2. The United States Food and Drug Administration;
  3. The United States Department of Defense;
  4. The United States Department of Veteran’s Affairs;
  5. The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks; or
  6. A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

Benefits do not, however, include the following:

- A health care service, item, or drug that is the subject of the cancer clinical trial or is provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial;
- An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;
- A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

**Emergency Care and Urgent Care**

**Emergency Care (including Emergency Room Services)**

Medically Necessary services which We determine to meet the definition of Emergency Care will be covered. Hospitals generally are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency medical conditions and Emergency screening and stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions.
Benefits for Emergency Care include facility costs, Physician services, and supplies and prescriptions. When you are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Copayment for that Emergency Room visit will be waived. For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notifies Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a participation agreement with Us or is a BlueCard Provider, you will be financially responsible for any care determined to be not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care.

**Urgent Care Center Services**

Often an urgent rather than an Emergency medical problem exists. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and you are advised to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

See your Schedule of Benefits for benefit limitations.

**Obtaining Emergency or Urgent Care**

If you need Emergency Care or Urgent Care even while you are traveling outside of the Service Area, these are the step-by-step instructions you need to follow to help ensure you receive coverage.

- Know the difference between an Emergency and an Urgent Care situation.
- If you are experiencing an Emergency situation, call 9-1-1 or go to the nearest Hospital. If you are experiencing an Urgent Care medical problem, go to an Urgent Care center. If there is not one nearby, then go to the Hospital.
- Call your Physician or the Administrator within 48 hours.
- Ask if the Hospital or Urgent Care center contracts with the local Blue Cross and Blue Shield Plan.
- If the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan, show your Identification Card to the Hospital or Physician. If it does not contract with the local Blue Cross and Blue Shield Plan, you will need to pay the bill and file a claim form.
- If the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan, the Hospital or Urgent Care Center will verify your membership and get your benefit information from a nationwide electronic data system.
- After you are treated, your claim is sent to Us. You only have to pay the Hospital or Urgent Care Center any Copayments or Deductibles as stated in your Plan.
- You may receive an Explanation of Benefits form depending on what services you received.
Travel outside the country:

• Go to the nearest health care facility.
• Call your Physician or Us within 48 hours.
• Once your care is completed, you will need to pay the bill. (You may want to use a credit card. The credit card company will automatically transfer the foreign currency into American dollars for you.) Keep all your receipts!
• When you return home, call Us at the number on the back of your ID card or stop by your Group’s personnel office and ask for a claim form.
• Fill out the claim form and submit it with your receipts to Our address on the form. (The amount submitted must be in American dollars.)
• You will be reimbursed based on the benefits of your Plan.

Ambulance Services

Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals (other vehicles which do not meet this definition, including but not limited to ambulettes, are not Covered Services):

• From your home, scene of accident or medical Emergency to a Hospital;
• Between Hospitals;
• Between a Hospital and Skilled Nursing Facility; or
• From a Hospital or Skilled Nursing Facility to your home.

Ambulance services are a Covered Service only when Medically Necessary, except:

• When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member’s health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

Non Covered Services for Ambulance include but are not limited to, trips to:

• a Physician's office or clinic;
• a morgue or funeral home.

Diagnostic Services

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Preventive Care Services and Physician Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

• X-ray and other radiology services, including mammograms for any person diagnosed with breast disease;
• Magnetic Resonance Imaging (MRI);
• CAT scans;
• Laboratory and pathology services;
• Cardiographic, encephalographic, and radioisotope tests;
• Ultrasound services;
• Allergy tests;
• Electrocardiograms (EKG);
• Electromyograms (EMG) except that surface EMG's are not Covered Services;
• Echocardiograms;
• Bone density studies;
• Positron emission tomography (PET scanning).

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician’s office.

When Diagnostic radiology is performed in a Network Physician’s Office, no Copayment is required if stated in dollars. Any Copayment stated as a percentage will still apply.

Surgical Services

Coverage for Surgical Services when provided as part of Physician Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

• Performance of generally accepted operative and other invasive procedures;
• The correction of fractures and dislocations;
• Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
• Usual and related pre-operative and post-operative care; and
• Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

• Operative and cutting procedures;
• Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy and laparoscopy;
• Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Surgical Services for Morbid Obesity, described in more detail below, shall be covered the same as any other Medically Necessary Surgical Service.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

• Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
• Breast reconstruction resulting from a mastectomy. See “Mastectomy Notice” below for further coverage details.
• Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
• Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactyly;
• Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
• Tongue release for diagnosis of tongue-tied;
• Congenital disorders that cause skull deformity such as Crouzon’s disease;
• Cleft lip;
• Cleft palate.

Health Certificate
Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending Physician and will be subject to the same annual Deductible, Copayment provisions otherwise applicable under the Plan.

Morbid Obesity Treatment Services

Covered Services include surgical treatment of morbid obesity:

- that has persisted for at least five (5) years; and
- for which nonsurgical treatment supervised by a Physician has been unsuccessful for at least six (6) consecutive months.

Under state law, We cannot cover services for the surgical treatment of morbid obesity for a Member younger than 21 years of age unless two (2) Physicians licensed under Indiana Code 25-22.5 (one who holds the degree of doctor of medicine or doctor of osteopathy or its equivalent and who holds a valid unlimited license to practice medicine or osteopathic medicine in Indiana) determine that the surgery is necessary to:

- save the life of the Member; or
- restore the Member’s ability to maintain a major life activity (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency);

and each Physician documents in the Member's medical record the reason for the Physician’s determination.

“Morbid obesity” means:

- a body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- a body mass index of at least forty (40) kilograms per meter squared without comorbidity.

For purposes of this subsection, body mass index equals weight in kilograms divided by height in meters squared.

Therapy Services

Coverage for Therapy Services when provided as part of Physician Office Services, Inpatient Facility Services, Outpatient Services, or Home Care Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- Physical therapy including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.

- Speech therapy for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, and vocational therapies (e.g. hobbies, arts and crafts).

- **Spinal manipulation services** to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulation whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Spinal Manipulations as specified in the Schedule of Benefits.

**Other Therapy Services**

- **Cardiac rehabilitation** to restore an individual’s functional status after a cardiac event. Home programs, on-going conditioning and maintenance are not covered.

- **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents.

- **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of coverage the Plan will not require you to receive dialysis treatment at a Participating Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Participating Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Participating Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes.

- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

**Physical Medicine and Rehabilitation Services**

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient’s ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Certain Therapy Services rendered on an Inpatient or Outpatient basis are limited. See the Schedule of Benefits.

**Home Care Services**

Services performed by a Home Health Care Agency or other Provider in your residence. The services must be provided on a part-time visiting basis according to a course of treatment. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services
• Therapy Services (Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.)
• Medical/Surgical Supplies
• Durable Medical Equipment
• Prescription Drugs (only if provided and billed by a Home Health Care Agency)
• Private Duty Nursing

Home infusion therapy is covered and includes a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes services and supplies for Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, IV pain management and IV home chemotherapy.

Hospice Services
Hospice care may be provided in the home or Hospice for medical, social and psychological services used as palliative treatment for patients with a terminal illness and includes routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician.

Covered Services include the following:
• Skilled Nursing Services (by an R.N. or L.P.N.)
• Diagnostic Services
• Physical, speech and inhalation therapies
• Medical supplies, equipment and appliances
• Counseling services (except bereavement counseling)
• Inpatient confinement at a Hospice
• Prescription Drugs obtained from the Hospice

Human Organ and Tissue Transplant Services
For cornea and kidney transplants, the transplant and tissue services benefits or requirements described below do not apply. These services are paid as Inpatient Services, Outpatient Services or Physician Office Services depending where the service is performed.

Covered Transplant Procedure
Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services - All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member’s appropriateness for a Covered Transplant Procedure.

Notification
We strongly encourage the Member to call Our transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Customer Service telephone number on the back of your Identification card and ask for the transplant coordinator. We will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any Medical Policies, network requirements or Certificate exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Health Certificate
**Covered Transplant Benefit Period**

Starts one day prior to a Covered Transplant Procedure and continues for 364 days. If, within this time frame, a second Covered Transplant Procedure occurs, the Covered Transplant Benefit Period will begin one day prior to the second Covered Transplant Procedure and continue for 364 days.

**Transportation and Lodging**

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

**Medical Supplies, Equipment, and Appliances**

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Covered Services include, but are not limited to:

- **Medical and surgical supplies** - Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly. Prescription drugs and biologicals that cannot be self administered and are provided in a Physician's office, including but not limited to, Depo-Provera.

Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

- **Durable medical equipment** - The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, oxygen equipment. Rental costs must not be more than the purchase price. Repair of medical equipment is covered. Non-covered items include but are not limited to air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports, and corsets or other articles of clothing.

- **Prosthetic appliances** - Artificial
substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues; or
2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant)
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women’s Health and Cancer Rights Act;
4. Minor devices for repair such as screws, nails, sutures and wire mesh;
5. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
6. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses are covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered;
7. Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract - formulae and supplies are also covered)
8. Cochlear implant;
9. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care;
10. Restoration prosthesis (composite facial prosthesis);
11. Electronic speech aids in post-laryngectomy or permanently inoperative situations;
12. “Space Shoes” when used as a substitute device when all or a substantial portion of the forefoot is absent;
13. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth;
2. Dental appliances;
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4. Artificial heart implants;
5. Hairpieces for male pattern alopecia (baldness);
6. Wigs (except as described above following cancer treatment);
7. Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit Our website at www.anthem.com.

• **Orthotic devices** - Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered orthotic devices may include, but are not limited to, the following:

1. Cervical collars;
2. Ankle foot orthosis;
3. Corsets (back and special surgical);
4. Splints (extremity);
5. Trusses and supports;
6. Slings;
7. Wristlets;
8. Built-up shoe;
9. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

Non-Covered Services include but are not limited to:

1. Orthopedic shoes (except therapeutic shoes for diabetics);
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
4. Garter belts or similar devices.

If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card or visit Our website at www.anthem.com.

• **Prosthetic limbs & Orthotic custom fabricated brace or support** - Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1. determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
2. not solely for comfort or convenience.
Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan. They are also subject to a separate Lifetime Maximum and do not apply to the Plan Lifetime Maximum.

### Dental Services

#### Related to Accidental Injury

Outpatient Services, Physician Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient’s condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- x-rays;
- tests and laboratory examinations;
- restorations;
- prosthetic services;
- oral surgery;
- mandibular/maxillary reconstruction;
- anesthesia.

#### Other Dental Services

The only other dental expenses that are Covered Services are facility charges for Outpatient Services. Benefits are payable only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

### Dental Care

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member who is physically or mentally disabled, are covered if the Member requires dental treatment to be rendered in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the utilization standards for determining whether performing dental procedures necessary to treat the Member’s condition under general anesthesia constitutes appropriate treatment. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

### Maternity Services

Maternity Services include Inpatient Services, Outpatient Services and Physician Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a well newborn.
NOTE: If a newborn child is required to stay as an Inpatient past the mother’s discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Prenatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
  1. The antepartum, intrapartum, and postpartum course of the mother and infant;
  2. The gestational stage, birth weight, and clinical condition of the infant;
  3. The demonstrated ability of the mother to care for the infant after discharge; and
  4. The availability of postdischarge follow-up to verify the condition of the infant after discharge.

- Covered Services include at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than 48 hours following you and your newborn child’s discharge from the Hospital. Coverage includes, but is not limited to:
  1. Parent education;
  2. Physical assessments;
  3. Assessment of the home support system;
  4. Assistance and training in breast or bottle feeding;
  5. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician’s office.

In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

- Phenylketonuria;
- Hypothyroidism;
- Hemoglobinopathies, including sickle cell anemia;
- Galactosemia;
- Maple Syrup urine disease;
- Homocystinuria;
- Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
- Physiologic hearing screening examination for the detection of hearing impairments.
- Congenital adrenal hyperplasia;
- Biotinidase deficiency;
- Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.
Mental Health/Substance Abuse Services

See the Schedule of Benefits for any applicable Deductible and Copayment information. Coverage for the Inpatient and Outpatient treatment of Mental Health Conditions (including Substance Abuse) is provided in compliance with state and federal law.

Pervasive Developmental Disorder Services

Coverage is provided for the treatment of pervasive developmental disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Pervasive developmental disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Coverage for services will be provided as prescribed by the Member's treating Physician in accordance with a treatment plan. Any exclusion or limitation in this Certificate in conflict with the coverage described in this provision will not apply. Coverage for the treatment of pervasive developmental disorder will not be subject to dollar limits, Deductibles, or Copayment provisions that are less favorable than the to dollar limits, Deductibles, or Copayment provisions that apply to a physical illness as covered under this Certificate.

EXCLUSIONS

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1. Which We determine are not Medically Necessary or do not meet Our medical policy, Clinical Coverage Guidelines, or benefit policy guidelines.

2. Received from an individual or entity that is not a Provider, as defined in this Certificate, or recognized by Us.

3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us;

4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation;

6. For illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.

7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident;

8. For care required while incarcerated in a federal, state or local penal institution or
required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

9. For any Pre-Existing Condition for the time period specified in the Schedule of Benefits, subject to the Portability provision of this Certificate. This Exclusion is not applicable to newborns, adopted children or children placed for adoption who are enrolled under this Certificate within 31 days of the date of birth or placement for adoption.

10. For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

11. For court ordered testing or care unless Medically Necessary;

12. For which you have no legal obligation to pay in the absence of this or like coverage;

13. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;

14. Prescribed, ordered, or referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law or self.

15. For completion of claim forms or charges for medical records or reports unless otherwise required by law;

16. For missed or canceled appointments;

17. For mileage costs or other travel expenses, except as authorized by Us;

18. For which benefits are payable under Medicare Part A and/or Medicare Part B or would have been payable if a Member had applied for Parts A and/or Part B, except, as specified elsewhere in this Certificate or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if they had enrolled.

19. Charges in excess of the Maximum Allowable Amount;

20. Incurred prior to your Effective Date;

21. Incurred after the termination date of this coverage except as specified elsewhere in this Certificate;

22. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

23. Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable;

24. For Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a professional.

25. For Residential Treatment services. Residential treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a Physician weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.

26. For foot care only to improve comfort or appearance including, but not limited to care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails except when Medically
Necessary including but not limited to, foot care for diagnosis of diabetes or for impaired circulation to the lower extremities.

27. For any treatment for teeth, gums or tooth related service except as otherwise specified in this Certificate;

28. Related to weight loss or weight loss programs whether or not they are under medical or Physician supervision. Weight loss programs for medical reasons are also excluded. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.

29. For sex transformation surgery and related services, or the reversal thereof;

30. For marital counseling;

31. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery including but not limited to cataract surgery, or for soft contact lenses due to a medical condition.

32. For hearing aids or examinations for prescribing or fitting them;

33. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein;

34. For sterilization procedures, except when Medically Necessary;

35. For reversal of sterilization;

36. For artificial insemination; fertilization (such as in vitro or GIFT) or procedures and testing related to fertilization;

37. For personal hygiene, environmental control, or convenience items including but not limited to: air conditioners, humidifiers, physical fitness equipment; personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor’s meals; charges for failure to keep a scheduled visit; for non-medical self-care except as otherwise stated; purchase or rental of supplies for common household use, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program; for a health spa or similar facility.

38. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by Anthem.

39. For care received in an emergency room which is not Emergency Care, except as specified in this Certificate. This includes, but is not limited to suture removal in an emergency room.

40. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation radial keratotomy or keratomileusis or excimer laser refractive keratectomy.

41. Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices (LVAD) when used as a bridge to a heart transplant.

42. For expenses incurred at a health spa or similar facility;

43. For self-help training and other forms of non-medical self care, except as otherwise provided herein;

44. For examinations relating to research screenings;

45. For stand-by charges of a Physician;
46. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes;

47. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility.

48. For Private Duty Nursing Services except when provided through the Home Care Services benefit.

49. Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

50. For elective abortions, except for spontaneous abortions or when necessary to safeguard the mother’s life.

51. For oral contraceptive drugs, contraceptive devices, or other forms of contraception;

52. For Prescription Legend Drugs or Mail Service drugs.

53. Services and supplies related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

54. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

55. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.

56. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

57. Treatment of telangiectatic dermal veins (spider veins) by any method.

58. Reconstructive services except as specifically stated in the Covered Services section of this Certificate, or as required by law.

59. For room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission for your condition.

60. For supervised living or halfway houses.

61. For services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
How to Obtain Benefits

A claim must be filed for you to get benefits. Many Hospitals, Physicians, and Other Providers will submit your claim for you. If you submit the claim yourself, you should use a claim form.

Maximum Allowed Amount

General

This section describes how We determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by Participating and Non-Participating Providers is based on this Certificate’s Maximum Allowed Amount for the Covered Service that You receive. Please see the BlueCard section for additional information.

The Maximum Allowed Amount for this Certificate is the maximum amount of reimbursement We will allow for services and supplies:

• that meet Our definition of Covered Services, to the extent such services and supplies are covered under your Certificate and are not excluded;

• that are Medically Necessary; and

• that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your Certificate.

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met your Deductible or have a Copayment or Coinsurance. In addition, when You receive Covered Services from a Non-Participating Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

When You receive Covered Services from Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Physician or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Network Provider is a Provider who has signed a Participating agreement with Us.

For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Certificate is the rate the Provider has agreed with Us to accept as reimbursement for
the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Non-Participating Providers.

For Covered Services You receive from a Non-Participating Provider, the Maximum Allowed Amount for this Certificate will be one of the following as determined by Us:

1. An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services for the same services or supplies; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers’ fees and costs to deliver care, or

4. An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or

5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods shown above.

Providers who are not contracted for this product, but are contracted for other products with Us are also considered Non-Participating. For this Certificate, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between Us and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send You a bill and collect for the amount of the Provider’s charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower Out of Pocket costs to You. Please call Customer Service for help in finding a Participating Provider or visit Our website at www.anthem.com.

Customer Service is also available to assist You in determining this Certificate’s Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Us to assist You, You will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider’s charges to calculate your Out of Pocket responsibility. Although Customer Service can assist You with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs: The Maximum Allowed Amount is the amount determined by Us using prescription drug cost information provided by the Pharmacy Benefits Manager (PBM).

**Member Cost Share**

For certain Covered Services and depending on your plan design, You may be required to pay a
part of the Maximum Allowed Amount as Your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by a Participating or Non Participating Provider. Both services specifically excluded by the terms of your Plan and those received after benefits have been exhausted are non-Covered Services. Benefits may be exhausted by exceeding, for example, your Lifetime Maximum, benefit caps or day/visit limits.

Services Performed During Same Session

We may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to Our Maximum Allowable Amount. If services are performed by Non Participating Providers, then you are responsible for any amounts charged in excess of Our Maximum Allowable Amount with or without a referral or regardless if allowed as an Authorized Service. Contact Us for more information.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which we provide benefits under this Certificate. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, except as required by a “Qualified Medical Child Support order” as defined by ERISA.

Once a Provider gives a Covered Service, we will not honor a request for Us to withhold payment of the claims submitted.

Assignment

This Certificate is not assignable by the Group without the written consent of the Plan. The coverage and any benefits under this Certificate are not assignable by any Member without the written consent of the Plan, except as provided above.

Notice of Claim

We are not liable under the Certificate, unless We receive written notice that Covered Services have been given to you. The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.
Claim Forms

Many Providers will file for you. If the forms are not available, either send a written request for claim forms to Us or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician’s signature

Proof of Claim

Written proof of claim satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of claim is not sent within the time required, the claim will not be reduced or denied if it was not possible to do send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive. We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member’s Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker’s Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

BlueCard

When you obtain health care services through the BlueCard Program outside the geographic area We serve, the amount you pay for Covered Services is calculated on the lower of:
• The billed charges for your Covered Services, or

• The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes onto Us.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, We would then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider’s service(s) will be considered Non-Participating care and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card or go to www.anthem.com for more information about such arrangements.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

• Total amounts charged for services/supplies received

• The amount of the charges satisfied by your coverage

• The amount for which you are responsible (if any)

• General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

Entire Contract

Note: the laws of the state in which the Group Contract was issued will apply unless otherwise stated herein. This Certificate, the Group Contract, the Group application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire Contract between the Plan and the Group and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Group and any and all statements made to the Group by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage.
under this Certificate, shall be used in defense to a claim under this Certificate.

**Form or Content of Certificate**

No agent or employee of the Plan is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by an officer of the Plan.

**Disagreement with Recommended Treatment**

You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider’s judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

**Circumstances Beyond the Control of the Plan**

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Provider’s personnel or similar causes, or the rendering of health care services provided under this Certificate is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Providers shall render health care services provided under this Certificate insofar as practical, and according to their best judgment; but the Plan and Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

**Coordination of Benefits**

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Certificate, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Certificate, Plan has the meaning listed in the Definitions section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans’ allowable amounts. A Participating Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans’ allowable amounts. This higher allowable amount may be more than Our Maximum Allowable Amount.

**COB DEFINITIONS**

- **Plan** is any of the following that provides benefits or services for medical or dental care or
treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether “fault” or “no fault”); Other governmental benefits, except for Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

**This Plan** means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan’s benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

**Allowable expense** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If you are covered by 2 or more Plans that provide benefits or services on the basis of...
negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.

6. The amount that is subject to the Primary high-deductible health plan's deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

7. Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law,
Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

**Rule 2 - Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
   - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   - If a court decree states that one of the parents is responsible for the Dependent child’s health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   - If a court decree states that both parents are responsible for the Dependent child’s health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
   - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
   - If there is no court decree assigning responsibility for the Dependent child’s health care expenses or health care coverage, the order of benefits for the child are as follows:
     - The Plan covering the Custodial parent;
     - The Plan covering the spouse of the Custodial parent;
     - The Plan covering the non-custodial parent; and then
     - The Plan covering the spouse of the non-custodial parent.

3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

**Rule 3 - Active Employee or Retired or Laid-off Employee.** The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if “Rule 1 - Non-Dependent or Dependent” can determine the order of benefits.

**Rule 4 - COBRA or State Continuation Coverage.** If you are covered under COBRA or under a right of continuation provided by state or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule
does not apply if “Rule 1 - Non-Dependent or Dependent” can determine the order of benefits.

**Rule 5 - Longer or Shorter Length of Coverage.** The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

**Rule 6.** If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

**EFFECT ON THE BENEFITS OF THIS PLAN**

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans’ allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

**RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

**FACILITY OF PAYMENT**

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

**RIGHT OF RECOVERY**

If the amount of the payments made by Us is more than should have been paid under this COB provision, We may recover the excess from one or more of the persons:

1. We have paid or for whom We have paid; or
2. Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.
**Medicare**

Any benefits covered under both this Certificate and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services (CMS) guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Certificate provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Certificate for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if they had enrolled.

**Worker’s Compensation**

The benefits under this Certificate are not designed to duplicate any benefit for which Members are eligible under the Worker’s Compensation Law. All sums paid or payable by Worker’s Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker’s Compensation.

**Other Government Programs**

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under the Plan shall not duplicate any benefits to which Members are entitled or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

**Subrogation/Reimbursement**

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

**Subrogation**

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.
Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.
- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
  1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
  2. you fail to cooperate.
- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

    You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

    We have oversight responsibility for compliance with Provider and vendor and
Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

**Modifications**

By this Certificate, the Group makes the Plan coverage available to eligible Members. However, this Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Group Contract, or by mutual agreement between the Plan and the Group without the consent or concurrence of any Member. By electing medical and hospital coverage under the Plan or accepting the Plan benefits, all Members legally capable of contracting and the legal representatives of all Members incapable of contracting agree to all terms, conditions, and provisions hereof.

**Relationship of Parties (Group-Member-Plan)**

Neither the Group nor any Member is the agent or representative of the Plan.

The Group is fiduciary agent of the Member. The Plan’s notice to the Group will constitute effective notice to the Member. It is the Group’s duty to notify the Plan of eligibility data in a timely manner. The Plan is not responsible for payment of Covered Services of Members if the Group fails to provide the Plan with timely notification of Member enrollments or terminations.

**Interpretation of Certificate**

The laws of the State in which the Certificate is issued shall be applied to the interpretations of this Certificate.

**Clerical Error**

Clerical error, whether of the Group or the Plan, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

**Medical Examination**

We have the right to have a Physician examine you as often as is reasonably required while we are processing a claim. We will notify you in advance.

**Legal Action**

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan’s Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.
**Provider Reimbursement**

Benefits shown in this Certificate or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount allowance or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your Payment Maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

**Waiver**

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Certificate, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

**Plan’s Sole Discretion**

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

**Reservation of Discretionary Authority**

The following provision only applies where the interpretation of this Certificate is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

The Plan, or anyone acting on Our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, We, or anyone acting on Our behalf, has complete discretion to determine the administration of Your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental-Investigative, whether surgery is cosmetic, and whether charges are consistent with our Maximum Allowable Amount. However, a Member may utilize all applicable Member Grievance procedures.

The Plan, or anyone acting on Our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with...
with the operation and administration of the Certificate. This includes, without limitation, the power to construe the Group Contract, to determine all questions arising under the Certificate, to resolve Member Grievances and Appeals, and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Group Contract the Certificate, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

**Anthem Insurance Companies, Inc. Note**

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this policy constitutes a contract solely between the Group and Anthem Insurance Companies, Inc. (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

**13 MEMBER GRIEVANCES**

**Grievances**

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a signed Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the grievance from the member or the member’s provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business
hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, mail it to: Anthem Appeals, P.O. Box 33200, Louisville, KY 40232-3200, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 5 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but not later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance does not relate to an adverse certification decision (i.e., Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

**Appeals**

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the appeal for consideration by the appeal panel whether or not You choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting, unless your Appeal qualifies for Expedited Review. Appeals concerning adverse certification decisions or the denial of any other prior authorization required by the Plan will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business
days in writing by Us of Our decision concerning your Appeal.

**Expedited Review**

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

**External Grievance**

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

- Your Appeal is regarding:

  1. an adverse determination of appropriateness; or
  2. an adverse determination of medical necessity; or
  3. a determination that a proposed service is Experimental/Investigational made by Us or an agent of Ours regarding a service proposed by the treating physician; and

- You or your representative request the External Grievance in writing within forty-five (45) days after You are notified of the Appeal panel’s decision concerning your Appeal; and

- The service is not specifically excluded in this Certificate.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization’s determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

**Grievance/Appeal Filing Time Limit**

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is received by Us after the end of the calendar year plus 12 months have passed since the incident leading to your Grievance. We will accept Appeals filed within 60 days after you are notified of our decision concerning your Grievance. We will
accept External Grievance requests filed within 45 days after you are notified of our Appeal decision.

**Grievances and Appeals by Members of ERISA Plans**

If you are covered under a Group plan which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you must file a Grievance prior to bringing a civil action under 29 U.S.C. 1132 §502(a). An Appeal of a Grievance decision is a voluntary level of review and need not be exhausted prior to filing suit. Any statutes of limitations or other defenses based upon timeliness will be tolled while an Appeal is pending. You will be notified of your right to file a voluntary Appeal if Our response to your Grievance is adverse. Upon your request, We will also provide you with detailed information concerning an Appeal, including how panelists are selected.

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**Notice to Members**

*Questions regarding your coverage should be directed to:*

**Anthem Insurance Companies, Inc.**  
1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us, you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance  
Consumer Services Division  
311 W. Washington Street, Suite 300  
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi
Vision Certificate of Coverage

(herein called the “Certificate”)

Blue View Vision

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204
Welcome to Anthem Blue Cross and Blue Shield! This Certificate has been prepared by Us to help explain your vision care benefits. Please refer to this Certificate whenever you require vision services. It describes how to access vision care, what vision services are covered by Us, and what portion of the vision care costs you will be required to pay.

The coverage described in this Certificate is subject in every respect to the provisions of the Group Contract issued to the Group. The Group Contract and this Certificate and any amendments or riders attached to the same, shall constitute the Group Contract under which Covered Services and supplies are provided by Us.

This Certificate should be read in its entirety. Since many of the provisions of this Certificate are interrelated, you should read the entire Certificate to get a full understanding of your coverage.

Many words used in the Certificate have special meanings. These words appear in capitals and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. The Certificate also contains exclusions.

This Vision Certificate supersedes and replaces any Vision Certificate previously issued to you under the provisions of the Group Contract.

Read your Certificate Carefully. The Certificate sets forth many of the rights and obligations between you and the Plan. Payment of benefits is subject to the provisions, limitations and exclusions of your Certificate. It is therefore important that you read your Certificate.

[Signature]
President
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1 SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the amount of benefits available when you receive Covered Services from a Provider. Please refer to the Covered Services section for a more complete explanation of the specific vision services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of the Certificate including any attachments or riders.

CHOICE OF VISION CARE PROVIDER: Nothing contained in this Certificate restricts or interferes with your right to select the Vision Care Provider of your choice, but your benefits are reduced when you use a Non-Network Provider.

DEPENDENT AGE LIMIT

To the end of the Calendar Year in which the child attains age 24

COVERED SERVICES

Exam

Limited to one exam per Member every 12 months.* Each exam must be 12 months from the date of the last exam to be covered.

*C from the Last Date of Service.

Laser Vision Correction Services

Participating Lasik/photorefractive keratectomy PRK surgical centers offer a discounted rate for Members enrolled under this plan. You are responsible for any remaining charges.

2 DEFINITIONS

This section defines terms that have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Actively at Work - Present and capable of carrying out the normal assigned job duties of the Group. Subscribers who are absent from work due to a health related disability, maternity leave or regularly scheduled vacation will be considered Actively At Work.

Additional Savings Program – A discount program included in the vision benefit program. It can be used with certain non-covered services and plan overages. The discount plan is subject to change at any time.

Certificate - This summary of the terms of your benefits. It is attached to and is a part of the Group Contract and is subject to the terms of the Group Contract.

Coinsurance - A percentage of the Maximum Allowable Amount for which you are responsible to pay. Your Coinsurance will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment - A specific dollar amount indicated in the Schedule of Benefits for which you are responsible.

Covered Services - Services and supplies or treatment as described in the Certificate which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service, the services, supply or treatment must be:

- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Certificate is in force;
• Within the Maximum Allowable Amount;

• Not specifically excluded or limited by the Certificate;

• Specifically included as a benefit within the Certificate.

A Covered Service is incurred on the date the service, supply or treatment was provided to you.

**Dependent** - A Subscriber's spouse and unmarried dependent children who have met Our eligibility requirements and have not reached the age limit shown in the Schedule of Benefits.

**Effective Date** - The date when your coverage begins under this Certificate. A Dependent’s coverage begins on the Effective Date of the sponsoring Subscriber.

**Elective Contact Lenses** - All prescription contact Lenses that are cosmetic in nature or Non-Elective Contact Lenses.

**Eligible Person** - A person who satisfies the Group’s eligibility requirements and is entitled to apply to be a Subscriber.

**Enrollment Date** - The first day of coverage or, if there is a waiting period, the first day of the waiting period (typically the date employment begins).

**Family Coverage** - Coverage for the Subscriber and eligible Dependents.

**Group** - The employer or other entity or trust that has entered into a Group Contract with the Plan.

**Group Contract (or Contract)** - The contract between the Plan and the Group. It includes this Certificate, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

**Identification Card** - A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

**Last Date of Service** - The period of time in which benefits are tracked. The Member must wait until the specific interval from the last date of service to receive Covered Services as listed in the Schedule of Benefits.

**Late Enrollee** – An Eligible Person whose enrollment did not occur on the earliest date that coverage can become effective under this Certificate, and who did not qualify for Special Enrollment.

**Lenses** - Materials prescribed for the visual welfare of the patient. Materials would include single vision, bifocal, trifocal or other more complex lenses.

**Maximum Allowable Amount** - The maximum amount allowed for Covered Services you receive based on the fee schedule. The Maximum Allowable Amount is subject to any Copayments, Coinsurance, limitations or Exclusions listed in this Certificate.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount.

For a Non-Network Provider who is a physician or other non-facility Provider, even if the Provider has a participation agreement with Us for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for this Product.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its agreement with Us.

**Member** - A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called “you” and “your.”

**Network Provider** - A Provider who has entered into a contractual agreement or is otherwise engaged by Us to provide Covered Services and certain administration functions for the Network associated with this Certificate.

**Non-Elective Contact Lenses** - Contact Lenses which are provided for reasons that are not
cosmetic in nature. Non-Elective Contact Lenses are Covered Services when the following conditions have been identified or diagnosed:

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

Non-Network Provider - A Provider who has not entered into a contractual agreement with Us for the Network associated with this Certificate.

Open Enrollment – A period of enrollment designated by the Plan in which Eligible Persons or their Dependents can enroll without penalty after the initial enrollment; see the Eligibility and Enrollment section for more information.

Plan (or We, Us, Our) – Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield which provides benefits to Members for the Covered Services that are described in this Certificate.

Premium - The periodic charges that the Member or the Group must pay the Plan to maintain coverage.

Provider - A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that We approve. This includes any Provider rendering services that are required by applicable state law to be covered when rendered by such Provider.

Subscriber - An eligible employee or Member of the Group who is eligible to receive benefits under the Group Contract.

3 ELIGIBILITY AND ENROLLMENT

You have coverage provided under this Certificate because of your employment with/membership with/ retirement from the Group. You must satisfy certain requirements to participate in the Group's benefit plan. These requirements may include probationary or waiting periods and Actively At Work standards as determined by the Group or state and/or federal law and approved by Us.

Your Eligibility requirements are described in general terms below. For more specific eligibility information, see your Human Resources or Benefits Department.

Eligibility

The following eligibility rules apply unless you are notified by Us and the Group.

Subscriber

To be eligible to enroll as a Subscriber, an individual must:

- Be either: An employee, Member, or retiree of the Group, and:
- Be entitled to participate in the benefit plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and be Actively At Work;
- Meet the eligibility criteria stated in the Group Contract.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by
the Subscriber, meet all Dependent eligibility criteria established by the Group and be:

- The Subscriber's spouse as recognized under the laws of the state where the Subscriber lives.
- The following children, regardless of the level of support by the Subscriber: the Subscriber's natural children, newborn and legally adopted children, or children who the Group has determined are covered under a “Qualified Medical Child Support Order” as defined by ERISA or any applicable state law.
- The following children, if the Subscriber provides more than fifty percent (50%) of the child's total support: stepchildren, children for whom the Subscriber or the Subscriber's spouse is a legal guardian, or the Subscriber's or the Subscriber's spouse's grandchildren or other blood relatives.

All enrolled eligible, children will continue to be covered until the age limit listed in the Schedule of Benefits.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves due to mental retardation or physical or mental handicap. The Dependent's disability must start before the end of the period they would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must notify Us if the Dependent's status changes and they are no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

To obtain coverage for children, We may require that the Subscriber complete a “Dependency Affidavit” and provide Us with a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under this Certificate.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under the Plan unless required by the laws of this state.

Coverage Effective Dates and enrollment requirements are described in the Group Contract.

**College Student Medical Leave**

The Plan will extend coverage for up to one year when a college student otherwise would lose eligibility, if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

*Medically Necessary change in student status.* The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status). The Plan must receive written certification from the child's Physician confirming the serious illness or injury and the Medical Necessity of the leave or change in status.

**Enrollment**

**Initial Enrollment**

An Eligible Person can enroll for Single or Family Coverage by submitting an application to the Plan. The application must be received by the date stated on the Group Contract or the Plan's underwriting rules for initial application for enrollment. If We do not receive the initial application by this date, the Eligible Person can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, which ever is applicable.

If a person qualifies as a Dependent but does not enroll when the Eligible Person first applies for enrollment, the Dependent can only enroll for
coverage during the Open Enrollment period or during a Special Enrollment period, which ever is applicable.

It is important for you to know which family members are eligible to apply for benefits under Family Coverage. See the section on eligible Dependents.

**Newborn and Adopted Child Coverage**

Any Dependent child born while the Subscriber or Member's spouse is eligible for coverage will be covered from birth for a period of 31 days. Any Dependent child adopted while the Subscriber or the Member's spouse is eligible for coverage will be covered from the date of placement for purposes of adoption for a period of 31 days.

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you, and will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

To continue coverage beyond the 31 day period after the child's birth or adoption you must notify Us by submitting a Change of Status Form to add the child under the Subscriber’s Certificate. The Change of Status Form must be submitted within 31 days after the birth or placement of the child. If timely notice is given, an additional Premium for the coverage of the newborn child or adopted child will not be charged for the duration of the notice period. However, if timely notice is not given, We may charge an additional Premium from the child’s date of birth or placement for adoption.

If the child is not enrolled within 31 days of the date of birth or placement for adoption, coverage will cease.

**Adding a Child due to Award of Legal Custody or Guardianship**

If a Subscriber or the Subscriber’s spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage would start on the date the court granted legal custody or guardianship. If We do not receive an application within the 31-day period, the child will be treated as a Late Enrollee.

**Qualified Medical Child Support Order**

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child under this Certificate, We will permit your child to enroll at any time without regard to any Open Enrollment limits and shall provide the benefits of this Certificate in accordance with the applicable requirements of such order. A child’s coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under this Certificate will be paid, at Our discretion, to the child or the child’s custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

**Special Enrollment/Special Enrollees**

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other vision insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Plan, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If We receive an application to add your Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, that person is only eligible for coverage as a Late Enrollee.
Enrollee. Application forms are available from the Plan.

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or

- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program) under Medicaid or CHIP.

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If We receive an application to add your Dependent or an Eligible Person and Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, that person is only eligible for coverage as a Late Enrollee.

Application forms are available from the Plan.

Late Enrollees

You are considered a Late Enrollee if you are an Eligible Person or Dependent who did not request enrollment for coverage:

- During the initial enrollment period; or
- During a Special Enrollment period; or
- As a newly eligible Dependent who failed to qualify during the Special Enrollment period and did not enroll within 31 days of the date you were first entitled to enroll.

You may apply for coverage at any time during the year as a Late Enrollee. However, you will not be enrolled for coverage with the Plan until the next Open Enrollment Period.

Open Enrollment Period

An Eligible Person or Dependent who did not request enrollment for coverage during the initial enrollment period, or during a Special Enrollment period, may apply for coverage at any time, however, will not be enrolled until the Group's next annual enrollment.

Open Enrollment means a period of time (at least 31 days prior the Group's renewal date and 31 days following) which is held no less frequently than once in any 12 consecutive months.

Notice of Changes

The Subscriber is responsible to notify the Group of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Certificate. The Plan must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another dental plan. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of payments from the Group for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 31 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications by the Group must be in writing and on approved forms. Such notifications must include all information reasonably required to effect the necessary changes.

A Member's coverage terminates on the date such Member ceases to be in a class of Members eligible for coverage. The Plan has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's coverage.
**Effective Date of Coverage**

For information on your specific Effective Date of Coverage under this Certificate, please see your human resources or benefits department. You can also contact Us by calling the number located on the back of your Identification (ID) Card or by visiting www.anthem.com.

**Statements and Forms**

Subscribers or applicants for membership shall complete and submit applications, questionnaires or other forms or statements the Plan may reasonably request.

Applicants for membership understand that all rights to benefits under this Certificate are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a Member may result in termination of coverage as provided in the "Changes in Coverage: Termination, Continuation & Conversion" section.

**Delivery of Documents**

We will provide an Identification Card for each Member and a Certificate for each Subscriber.

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**4 TERMINATION, CONTINUATION AND CONVERSION**

**Termination**

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your Group’s agreement with Us and your specific circumstances, such as whether Premium has been paid in full:

- If you terminate your coverage, termination will generally be effective on the last day of the billing period in which We received your notice of termination.

- Subject to any applicable continuation or conversion requirements, if you cease to meet eligibility requirements as outlined in this Certificate, your coverage generally will terminate on the last day of the billing period. The Group and/or you must notify Us immediately if you cease to meet the eligibility requirements. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

- If you engage in fraudulent conduct or furnish Us fraudulent or misleading material information relating to claims or application for coverage, then We may terminate your coverage. Termination is generally effective 31 days after Our notice of termination is mailed, except when indicated otherwise in the Schedule of Benefits. We will also terminate your Dependent’s coverage, generally effective on the date your coverage is terminated. We will notify the Group in the event We terminate you and your Dependent’s coverage.

- A Dependent’s coverage will generally terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent, except when indicated otherwise in the Schedule of Benefits.

- If coverage is through an association, coverage will generally terminate on the date membership in the association ends.

- If you elect coverage under another carrier’s vision benefit plan or under any other non-Anthem plan which is offered by, through, or in connection with the Group as an option instead of this Certificate, then coverage for you and your Dependents will generally terminate at the end of the billing period for which Premium has been paid, subject to the consent of the Group. The
Group agrees to immediately notify Us that you have elected coverage elsewhere.

- If you permit the use of your or any other Member’s Plan Identification Card by any other person; use another person’s card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice to the Group. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for services received through such misuse.

Removal of Members

Upon written request through the Group, a Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member’s termination date.

Reinstatement

You will not be reinstated automatically if coverage is terminated. Re-application is necessary, unless termination resulted from inadvertent clerical error. No additions or terminations of membership will be processed during the time you or the Group’s request for reinstatement is being considered by Us. Your coverage shall not be adversely affected due to the Group’s clerical error. However, the Group is liable to Us if We incur financial loss as a result of the Group’s clerical error.

Continuation

Federal Continuation of Coverage (COBRA)

The following applies if you are covered under a Group which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group’s vision plan. It can also become available to other Members of your family, who are covered under the Group’s vision plan, when they would otherwise lose their vision coverage. For additional information about your rights and obligations under federal law under the coverage provided by the Group’s vision plan, you should contact the Group.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of vision coverage under the Group’s vision plan when coverage would otherwise end because of a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Group’s vision plan is lost because of the qualifying event. Under the Group’s vision plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Group for Premium payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group’s vision plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group’s vision plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct; or
• You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Group’s vision plan because any of the following qualifying events happens:

• The parent-Subscriber dies;
• The parent-Subscriber’s hours of employment are reduced;
• The parent-Subscriber’s employment ends for any reason other than his or her gross misconduct;
• The parents become divorced or legally separated; or
• The child stops being eligible for coverage under the Group’s vision plan as a “Dependent child.”

If Your Group Offers Retirement Coverage

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Group, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Group’s vision plan, the retired Subscriber will become a qualified beneficiary with respect to the bankruptcy. The retired Subscriber’s spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under Group’s vision plan.

When is COBRA Coverage Available

COBRA continuation coverage will be offered to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber’s becoming entitled to Medicare benefits (under Part A, Part B, or both), then you must notify the Group of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Subscriber and spouse or a Dependent child’s losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided

Once the Group receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the Subscriber, the Subscriber’s becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child’s losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber’s hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a covered Subscriber becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or
reduction of the Subscriber’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Group’s vision plan is determined by the Social Security Administration to be disabled and you notify the Group in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

If You Have Questions

Questions concerning your Group’s vision plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under this Certificate in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

“Military service” means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Certificate by notifying your employer in advance and payment of any required contribution for health coverage. This may include the amount the Employer normally pays on your behalf. If Your military service is for a period of time less than 31 days, You may not be required to pay more than the active Member contribution, if any, for continuation of health coverage.

If continuation is elected under this provision, the maximum period of health coverage under this Certificate shall be the lesser of:

1. The 18-month period (24 months if continuation is elected on or after 12/10/2004) beginning on the first date of your absence from work; or
2. The day after the date on which You fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under this Certificate. No exclusions or waiting period may be imposed on you or your eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

5 HOW TO OBTAIN COVERED SERVICES

Network Services and Benefits

If a Network Provider renders your care, benefits will be provided at the Network level. Refer to the Schedule of Benefits. No benefits will be provided for care that is not a Covered Service even if performed by a Network Provider.

We may inform you that a service you received is not a Covered Service under the Certificate. You may appeal this decision. See the Complaint and Appeals Procedures section of this Certificate.

Network Providers are professional Providers and other facility Providers who contract with Us to perform services for you. You will not be required to file any claims for services you obtain directly from Network Providers.

Non-Network Services and Benefits

Services that are not obtained from a Network Provider will be considered a Non-Network Service. In addition, certain services may not be covered unless obtained from a Network Provider, and/or may result in higher cost-share amounts. See your Schedule of Benefits. You will be required to file claims for services that you obtain directly from a Non-Network Provider.

Family and Medical Leave Act of 1993

A Subscriber who is taking a period of leave under the Family and Medical Leave Act of 1993 (the Act) will retain eligibility for coverage during this period. The Subscriber and his or her Dependents shall not be considered ineligible due to the Subscriber not being Actively At Work.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without underwriting and without imposition of an additional waiting period. To obtain coverage for a Subscriber upon return from leave under the Act, the Group must provide the Plan with evidence satisfactory to Us of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

Relationship of Parties (Plan - Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Provider or in any Provider’s facilities.

Your Network Provider’s agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to oth...
Providers, including Network and Non-Network Providers. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or Us.

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Certificate does not give anyone any claim, right, or cause of action against the Plan based on what a Provider of vision care, services or supplies, does or does not do.

6 COVERED SERVICES

This section describes the Covered Services available under your vision care benefits when provided and billed by eligible Providers. All Covered Services are subject to the exclusions listed in the Exclusions section and all other conditions and limitations of the Certificate. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider and whether or not you choose optional services and/or custom materials rather than standard services and supplies. Payment amounts are specified in the Schedule of Benefits.

The following are Covered Services:

- Routine Vision examinations

Services and materials obtained through a Non-Network Provider are subject to the same Exclusions and limitations as services through a Network Provider.

Vision Eye Examination

The Plan covers up to a comprehensive eye examination including dilation as needed minus any applicable Copayment. The eye examination may include the following:

- Case history
- Recording corrected and uncorrected visual acuity
- Internal exam

- External exam
- Pupillary reflexes
- Binocular vision
- Objective refraction
- Subjective refraction
- Glaucoma test
- Slit lamp exam (Biomicroscopy)
- Dilation
- Color vision
- Depth perception
- Diagnosis and treatment plan.

Cosmetic Options

Benefits are available for the services below in accordance with the Additional Savings Program. The Member will be responsible for the following items at a discounted rate when provided by a Network Provider.

- Blended Lenses
- Contact Lenses (except as noted herein)
- Oversize Lenses
- Progressive multifocal Lenses
- Photochromatic Lenses, or tinted Lenses
EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items that may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or supplies are Covered Services.

We do not provide vision benefits for services, supplies or charges:

1. Received from an individual or entity that is not a Provider, as defined in this Certificate.

2. For any condition, disease, defect, aliment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

3. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

4. For illness or injury that occurs as a result of any act of war, declared or undeclared.

5. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

6. For which you have no legal obligation to pay in the absence of this or like coverage.

7. Received from an optical or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.

8. Prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

9. For completion of claim forms or charges for medical records or reports unless otherwise required by law.

10. For missed or canceled appointments.

11. In excess of Maximum Allowable Amount.

12. Incurred prior to your Effective Date.

13. Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.

14. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

15. For sunglasses and accompanying frames.

16. For safety glasses and accompanying frames.

17. For inpatient or outpatient hospital vision care.

18. For Orthoptics or vision training and any associated supplemental testing.

19. For non-prescription lenses.
20. For two pairs of glasses in lieu of bifocals.
21. For Plano lenses (lenses that have no refractive power).
22. For medical or surgical treatment of the eyes.
23. For lost or broken Lenses or frames, unless the Member has reached his or her normal interval for service when seeking replacements.
24. For services or supplies not specifically listed in the Certificate.
25. Certain brands on which the manufacturer imposes a no discount policy.
26. For services or supplies combined with any other offer, coupon or in-store advertisement.

8 CLAIMS PAYMENT

Obtaining Services/Claim Payment

For services received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. If you elect to obtain services from a Non-Network Provider, you must pay the entire bill at the time the services are rendered. To request reimbursement for Covered Services We will need the following information:

- The name, address and phone number of the Non-Network Provider along with an itemized statement of charges
- The covered Member's name and address, group number, Social Security number or Member identification number
- The patient's name, birthdate and relationship to the Member

The Member should keep a copy of the information and send the originals to the following address:

BlueView Vision Claims Administration
PO Box 8504
Mason, OH 45040-7111

Assignment

This Certificate is not assignable by the Group without the written consent of the Plan. The coverage and any benefits under this Certificate are not assignable by any Member without the written consent of the Plan, except as described in this Certificate.

Notice of Claim

We are not liable under the Certificate, unless We receive written notice that Covered Services have been given to you. An expense is considered incurred on the date the service or supply was given.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice can be submitted later than one year after the usual 90 day filing period ends. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

Claim Forms

Many Providers will file for you. If the forms are not available, either send a written request for claim forms to Us or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services
rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient’s relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician’s signature

Proof of Claim

Written proof of claim satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of claim is not sent within the time required, the claim will not be reduced or denied if it was not possible to do send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Certificate, We may reimburse those other parties and be fully discharged from that portion of its liability.

Member’s Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker’s Compensation or any other governmental program. Any Member who fails to cooperate will be responsible for any charge for services.

Explanation of Benefits

After you receive vision care, you will often receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you received. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by your coverage;
- the amount for which you are responsible (if any);
- general information about your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.
9 GENERAL PROVISIONS

Entire Contract

Note: The laws of the state in which the Group Contract was issued will apply unless otherwise stated herein.

This Certificate, the Group Contract, the Group application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire Contract between the Plan and the Group and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Group and any and all statements made to the Group by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

Form or Content of Certificate

No agent or employee of the Plan is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by an officer of the Plan.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Plan, disability of a significant part of a Network Provider’s personnel or similar causes, or the rendering of vision care services provided under this Certificate is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render services provided under this Certificate insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Coordination of Benefits

We consider this Plan primary in all circumstances.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under this Certificate shall not duplicate any benefits to which Members are entitled or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 12 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, or Vendor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which
recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

**Relationship of Parties**  
*(Group-Member-Plan)*

Neither the Group nor any Member is the agent or representative of the Plan.

The Group is fiduciary agent of the Member. The Plan’s notice to the Group will constitute effective notice to the Member. It is the Group’s duty to notify the Plan of eligibility data in a timely manner. The Plan is not responsible for payment of Covered Services of Members if the Group fails to provide the Plan with timely notification of Member enrollments or termination’s.

**Conformity with Law**

Any provision of this Plan that is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

**Modifications**

This Certificate allows the Group to make the Plan coverage available to eligible Members. However, this Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Group Contract, or by mutual agreement between the Plan and the Group without the permission or involvement of any Member. Changes will not be effective until 30 days after We provide written notice to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting the Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Certificate.

**Clerical Error**

Clerical error, whether of the Group or the Plan, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

**Legal Action**

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan’s Complaint and Appeals Procedures before filing a lawsuit or other legal action of any kind against Us.

**Policies and Procedures**

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which a Member shall comply.

**Waiver**

No agent or other person, except an authorized officer of the Plan, is able to disregard any conditions or restrictions contained in this Certificate, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.
Plan’s Sole Discretion

The Plan may, in its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The following provision only applies where the interpretation of this Certificate is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

The Plan, or anyone acting on Our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, We, or anyone acting on Our behalf, has complete discretion to determine the administration of Your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are covered. However, a Member may utilize all applicable Grievance and Appeals Procedures.

The Plan, or anyone acting on Our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of the Certificate. This includes, without limitation, the power to construe the Group Contract, to determine all questions arising under the Certificate, to resolve Member Grievances and Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Group Contract the Certificate, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Anthem Blue Cross and Blue Shield

Note

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Certificate constitutes a contract solely between the Group and Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

10 COMPLAINT AND APPEALS PROCEDURES

Our customer service representatives are specially trained to answer your questions about Our vision benefit plans. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Copayment amounts;
- Specific claims or services you have received;
- Providers in the Network; and/or
- Provider directories.

You will be notified, in writing, if a claim or other request for benefits is denied in whole or in
part. If such a request is denied, the notice of denial will explain why benefits were denied and describe your rights under the Appeals Procedure. A Complaint Procedure also exists to help you understand the Plan’s determinations.

The Complaint Procedure

A Complaint Procedure is available to provide reasonable, informative responses to complaints that you may have concerning the Plan. A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Plan of its procedures and contracts. The Plan invites you to share any concerns that you may have over benefit determinations, coverage cancellations, or the quality of care rendered by Vision Providers in the Plan’s Networks.

If you have a complaint or problem concerning benefits or services, please contact Us. Please refer to your Identification Card for Our address and telephone number. You may submit your complaint by letter or by telephone call. Or, if you wish, you may meet with your local service representative to discuss your complaint.

Members are encouraged to file complaints within 60 days of an initial, adverse action, but must file within six months after receipt of notice of the initial, adverse action. The time required to review complaints does not extend the time in which appeals must be filed.

The Appeals Procedure

An appeal is a formal request from you for the Plan to change a previous determination. If you are notified in writing of a Coverage Denial or any other adverse decision by Us, you will be advised of your right to an internal appeal.

A Coverage Denial means Our determination that a service, treatment, drug or device is specifically limited or excluded under this Certificate.

The internal appeals process may be initiated by the Member, the Member’s authorized representative, or a Provider acting on behalf of the Member within 60 days of receipt of Our written notice of a Coverage Denial, or any other adverse decision made by Us, but must be filed within six months of your receipt of the initial decision. The request should include any medical information pertinent to the appeal. All portions of the medical records that are relevant to the appeal and any other comments, documents, records or other information submitted by the Member relating to the issue being appealed, regardless of whether such information was considered in making the initial decision, will be considered in the review of the appeal. Any new medical information pertinent to the appeal will also be considered. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member’s appeal.

If a representative is seeking an appeal on behalf of a Member, We must obtain a signed Designation of Representation (DOR) form from the Member. The appeal process will not begin until Anthem has received the properly completed DOR. We will forward a Designation of Representation form to the Member for completion.

The individuals responsible for reviewing your request for an internal appeal will not be the same individuals who made the initial denial or determination. They will not be the subordinates of the initial decision-maker either and no deference will be given to the initial decision.

Within a reasonable period of time but no later than 30 days after receiving a written or an oral request for an appeal, We will send a written decision to the Member or their authorized representative.

Contact Person For Appeals

The request for an internal appeal must be submitted to the following address or telephone number or to the appeal address or telephone number provided on your written notice of an adverse decision:

Blue View Vision
ATTN: Appeals
555 Middle Creek Parkway  
Colorado Springs, CO 80921

Telephone Number: 866-723-0515

The person holding the position named above will be responsible for processing your request.

The Plan encourages its Members to submit requests for appeal in writing. The request for appeal should describe the problem in detail. Attach copies of bills, medical records, or other appropriate documentation to support the appeal that may be in your possession.

You must file appeals on a timely basis. As stated above, you are encouraged to file internal appeals within 60 days of your receipt of the Plan's initial decision. Internal appeals must be filed, however, within six months of your receipt of the initial decision.

**Vision Services**

We are not liable for the furnishing of Covered Services, but merely for the payment of them. You shall have no claim against Us for acts or omissions of any Provider from whom you receive Covered Services. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

**Limitation of Actions**

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure before filing a lawsuit or other legal action of any kind against the Plan. If your vision benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.
Indiana Life and Health Insurance Guaranty Association Disclaimer
The Indiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in this state. Other conditions may also preclude coverage.

The Indiana Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Indiana Life and Health Insurance Guaranty Association when selecting an insurer.

You may contact the Indiana Life and Health Insurance Guaranty Association as follows:

Indiana Life and Health Insurance Guaranty Association
251 E. Ohio Street, Suite 1070
Indianapolis, Indiana 46204
(317) 636-8204
www.inlifega.org

You may contact the Indiana Department of Insurance as follows:

Indiana Department of Insurance
311 W. Washington Street
Indianapolis, IN 46204
(317) 232-2385
www.in.gov/doi
Notice of Privacy Practices
Information That's Important to You

Every year, we’re required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we’ve combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits

Want to save more trees? Go to anthem.com and sign up to receive these types of notices by e-mail.

State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers.

We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

HIPAA notice of privacy practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.
For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age; we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers’ Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.
Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.

- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.

- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.

- Send us a written request to ask us for a list of certain disclosures of your PHI.

- Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure. We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password Protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.
Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the

Women’s Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance. Contact your Plan administrator for more information.

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