

VISION BENEFIT BOOKLET

For

State of Indiana Vision Plan

Administered By



Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

If you need assistance in Spanish to understand this document, you may request it for free by calling Customer Service at the number on your identification card.

Effective 1-1-2016

The Plan settles claims based upon varying methodologies, which may be less than the Provider's billed charge. Please see the provision "Obtaining Services/Claim Payment" in the Claims Payment section of this Benefit Booklet for more details.

**BLUE VIEW VISION
Customer Service
1-866- 723-0515**

**Please Direct Appeals To:
Anthem Blue Cross and Blue Shield
Blue View Vision
Attn: Appeals Department
555 Middle Creek Parkway
Colorado Springs, CO 80921**

**Administered by:
Anthem,
an Independent Licensee of the Blue Cross and Blue Shield Association.**

Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments hereto are funded by the Employer who is responsible for their payment. The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

BENEFIT BOOKLET

This Benefit Booklet provides you with a description of your benefits while you are enrolled under the vision plan (the "Plan") offered by your Employer. You should read this booklet carefully to familiarize yourself with the Plan's main provisions and keep it handy for reference. A thorough understanding of your coverage will enable you to use your benefits wisely. If you have any questions about the benefits as presented in this Benefit Booklet, please contact your Employer's Group Vision Plan Administrator or call the Claims Administrator's Customer Service Department.

The Plan provides the benefits described in this Benefit Booklet only for eligible Members. The vision services are subject to the limitations, and exclusions, Copayments, Deductible and Coinsurance requirements specified in this Benefit Booklet. Any group vision plan or certificate which you received previously will be replaced by this Plan.

Anthem has been designated by your Employer to provide administrative services for the Employer's Group Vision Plan, such as claims processing and other services, and to arrange for a network of vision care *providers* whose services are covered by the Plan.

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Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross and Blue Shield Service Marks in portions of the State of Indiana. Anthem has entered into a contract with the Employer on its own behalf and not as the agent of the Association.

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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 Benefit Booklet including any attachments or riders.

Nothing contained in this Benefit Booklet restricts or interferes with your right to select the Vision Care Provider of your choice, but your benefits are reduced when you use an Out-of-Network Provider.

DEPENDENT AGE LIMIT: To the end of the month in which the child attains age 26. For additional Dependent information such as disabled dependent eligibility, see Eligibility and enrollment section of this booklet.

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network Providers	Out-of-Network Providers
Exam Limited to one exam per Member every 12 months.	\$10 Copayment	\$35 allowance
Prescription Lenses Basic Lenses (Pair) <ul style="list-style-type: none"> • Single Vision Lenses • Bifocal Lenses • Trifocal Lenses • Standard Polycarbonate (add-on the lens copay) Lens Option (paid by Member and added to the base price of the lens) <ul style="list-style-type: none"> • Tint • UV Coating • Standard Scratch-Resistant 	\$25 Copayment \$25 Copayment \$25 Copayment \$20 Copayment \$15 Copayment \$15 Copayment \$15 Copayment	\$25 allowance \$40 allowance \$55 allowance N/A N/A N/A N/A

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network Providers	Out-of-Network Providers
<ul style="list-style-type: none"> • Standard Progressive – (add-on bifocal) • Standard Anti-Reflective • Other Add-Ons <p>Limited to one set of lenses per Member every 12 months.</p>	<p>\$65 Copayment</p> <p>\$45 Copayment 20% off Retail</p>	<p>N/A</p> <p>N/A</p> <p>N/A</p>
<p>Frames</p> <p>Limited to one set of frames per Member every 24 months.</p>	<p>\$110 allowance</p>	<p>\$35 allowance</p>
<p>Contact Lens Fit and Follow-up</p> <ul style="list-style-type: none"> • Standard • Premium 	<p>\$40 Copayment</p> <p>10% off Retail</p>	<p>\$35 allowance</p> <p>\$35 allowance</p>
<p>Prescription Contact Lenses (traditional or disposable) – declining balance</p> <ul style="list-style-type: none"> • Elective Contact Lenses (Availability once every plan year.) • Elective Disposable Lenses (Availability once every plan year.) • Non-Elective Contact Lenses <p>Availability once every 12 months.</p>	<p>\$105 allowance</p> <p>\$105 allowance</p> <p>Covered in Full</p>	<p>\$95 allowance</p> <p>\$95 allowance</p> <p>\$165 allowance</p>
<p>Low Vision Benefits (Low Vision Benefits are subject to an allowance of \$1,000 per Member, lifetime maximum)</p>	<p>\$0 Copayment</p>	<p>\$0 Copayment</p>

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 Employer. 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.

Administrative Services Agreement – The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Vision Plan. This Benefit Booklet in conjunction with the Administrative Services Agreement, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Benefit Booklet or the Administrative Services Agreement and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Administrative Services Agreement, the Administrative Services Agreement shall control.

Benefit Booklet – This summary of the terms of your vision benefits.

Claims Administrator – An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Claims Administrator is Anthem. **The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.**

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 for Covered Services indicated in the Schedule of Benefits for which you are responsible.

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

- Within the scope of the license of the Provider performing the service;

- Rendered while coverage under the Plan is in force;
- Within the Maximum Allowable Amount;
- Not specifically excluded or limited by the Benefit Booklet;
- Specifically included as a benefit within the Benefit Booklet.

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

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

Effective Date - The date when your coverage begins under the Plan. 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 Employer's eligibility requirements and is entitled to apply to be a Subscriber.

Employer - An Employer who has allowed its employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides.

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.

Fees – The periodic charges which are required to be paid by you and/or the Employer to maintain benefits under the Plan.

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 the Plan, 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.

Low Vision – Any severe visual problem that is not substantially correctable with regular Lenses, including single Lenses, bifocal Lenses, and trifocal 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, limitations or Exclusions listed in this Benefit Booklet.

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 an Out-of-Network Provider who is a physician or other non-facility Provider, even if the Provider has a participation agreement with the Claims Administrator 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 the Claims Administrator.

Member - A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Fees have been paid. Members are sometimes called "you" and "your."

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

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.

Out-of-Network Provider - A Provider who has not entered into a contractual agreement with the Claims Administrator for the Network associated with this Benefit Booklet.

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 - The group vision benefit plan provided by the Employer and described in this Benefit Booklet.

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 that are required by applicable state law to be covered when rendered by such Provider.

Subscriber - An employee or member of the Employer who is eligible to receive benefits under the Plan.

ELIGIBILITY AND ENROLLMENT

- All active, full-time employees and their eligible "dependents" are eligible to participate. For the purpose of benefits eligibility, full-time employees are defined as active employees whose regular work schedule is at least 37 1/2 hours per week. Part-time, intermittent and hourly (temporary) employees who worked an average of thirty (30) or more hours per week over a 12-month review period would also be eligible for benefits. Part-time, intermittent and hourly (temporary) employees working less than thirty (30) or more hours per week over a 12-month review period are not eligible for insurance or related benefits.
- All appointed or elected officials and their eligible "dependents".
- Employees eligible under the Short and Long Term Disability Program remain eligible during the period of disability.

- "Dependent" means:

(a) Spouse of an employee;

(b) Any children, step-children, foster children, legally adopted children of the employee or spouse, or children who reside in the employee's home for whom the employee or spouse has been appointed legal guardian or awarded legal custody by a court, under the age of twenty-six (26). Such child shall remain a "dependent" for the entire calendar month during which he or she attains age twenty-six (26).

In the event a child:

i.) was defined as a "dependent", prior to age 19, and

ii.) meets the following disability criteria, prior to age 19:

(I) is incapable of self-sustaining employment by reason of mental or physical disability,

(II) resides with the employee at least six (6) months of the year, and

(III) receives 50% of his or her financial support from the parent

such child's eligibility for coverage shall continue, if satisfactory evidence of such disability and dependency is received by Anthem in accordance with Anthem's disabled dependent certification and recertification procedures. Eligibility for coverage of the "Dependent" will continue until the employee discontinues his coverage or the disability criteria is no longer met. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible Dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The plan requires periodic documentation from a physician after the child's attainment of the limiting age.

- A group health coverage program that is equal to that offered active employees shall be provided by the State for each “Retired Legislator”, dependent or spouse as defined and pursuant to the conditions set forth in IC 5-10-8.
- “Retirees” meeting the following criteria will continue to be eligible until they become eligible for Medicare:
 - (a) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
 - (b) Must have completed twenty (20) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement;
 - (c) Must have fifteen (15) years of participation in a retirement fund.
- “Retirees” meeting the following criteria will continue to be eligible until they become eligible for Medicare:
 - (a) Must retire after December 31, 2006;
 - (b) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
 - (c) Must have completed fifteen (15) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement.
- “Retirees” meeting the following criteria will continue to be eligible until they become eligible for Medicare:
 - (a) Must have been employed as a teacher in a State institution under IC 11-10-5, IC 12-24-3, IC 16-33-3, or IC 16-33-4;
 - (b) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
 - (c) Must have fifteen (15) years of service credit as a participant in the retirement fund of which the employee is a member on or before the employee’s retirement date; or must have completed ten (10) years of service credit as a participant in the retirement fund of which the employee is a member immediately before the employee’s retirement;
- A group health coverage program that is equal to that offered active employees shall be provided by the State for each “Retired Judge” who meets the following:
 - (a) Retirement date is after June 30, 1990;
 - (b) Will have reached the age of sixty-two (62) on or before retirement date;
 - (c) Is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;
 - (d) Who has at least eight (8) years of service credit as a participant in the Judge’s retirement fund, with at least eight (8) years of service credit completed immediately preceding the Judge’s retirement.
- A group health coverage program that is equal to that offered active employees shall be provided by the State for each “Retired Prosecuting Attorney” who meets the following:

- (a) Who is a retired participant under the Prosecuting Attorney's Retirement fund;
 - (b) Whose retirement date is after January 1, 1990;
 - (c) Who is at least sixty-two (62) years of age;
 - (d) Who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and
 - (e) Who has at least ten (10) years of service credit as a participant in the Prosecuting Attorneys retirement fund, with at least ten (10) years of service credit completed immediately preceding the participant's retirement.
- Retirees eligible under subsections 6 - 10 must file a written request for the coverage within ninety (90) days after retirement. At that time, the retiree may elect to have the retiree's spouse covered. The spouse's subsequent eligibility to continue insurance under the surviving spouse's eligibility end on the earliest of the following:
 - (a) Twenty-four (24) months from the date the deceased Retirees coverage is terminated. At the end of the period the Spouse would be eligible to remain covered until the end of the maximum period under COBRA;
 - (b) When the Spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.
 - (c) The end of the month following remarriage; or
 - (d) As otherwise provided by Act of the General Assembly.
 - Employee on a leave of absence for ninety (90) days or less and out of pay status.
 - An employee on family medical leave.
 - Retirees eligible under IC 5-10-12.
 - As otherwise provided by Act of the Indiana General Assembly.

Effective Date Of Your Coverage

“For specific information concerning your Effective Date of coverage under this Plan, you should see your Human Resources or benefits department.”

Coverage for a newborn child is effective from the moment of birth. Covered Services include the treatment of any injury or illness such as congenital deformity, hereditary complication, premature birth, and routine nursery care. Newborn must be formally added to Employee's policy through "family status" change process. See NEWBORN INFANT COVERAGE.

Newborn Infant Coverage

The benefits payable for covered Dependent children shall be paid for a sick or injured newborn infant of a Covered Person for the first 30 days of his or her life. The coverage for newly adopted children will be the same as for other covered

Dependents. The coverage for the newborn infant or newly adopted child consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage for the newborn infant or newly adopted child shall include, but not be limited to, benefits for Inpatient or Outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate.

The coverage required for a newly adopted child:

1. Is effective upon the earlier of:
 - a) The date of placement for the purpose of adoption; or
 - b) The date of the entry of an order granting the adoptive parent custody of the child for purpose of adoption;
2. Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; or
3. Continues unless required action as described below is not taken.

To be covered beyond the first 30 days, the newborn or newly adopted child must be added to the Covered Person's Plan Enrollment within the first 30 days after birth or adoption.

If the Enrollee must change to coverage with a higher fee to add the child, the Enrollee will be liable for the higher fee for the entire period of the child's coverage, including the first 30 days.

Federal Laws Related To Your Coverage

In the past few years, Congress has passed several laws that have affected our group health plans. These laws are designed to reduce Medicare expenditures by requiring that active employees and/or their Dependents who are either age 65 or over, or disabled to elect either:

- a) our group health Plan, or
- b) Medicare as their primary coverage.

The preference is option (a) since option (b) would require the discontinuance of the group medical Plan. In addition, Medicare no longer requires enrollment in the Part B Supplemental Medical Insurance Benefit for which there is a charge so long as you remain covered under our group medical Plan.

Special Enrollment/Special Enrollees

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 30 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 30 days after the marriage, birth, adoption, or placement for adoption.

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.

TERMINATION AND CONTINUATION

Termination of Coverage (Individual)

Membership for you and your enrolled family members may be continued as long as you are employed by the Employer and meet eligibility requirements. It ceases if your employment ends, if you no longer meet eligibility requirements, if the Plan ceases, or if you fail to make any required contribution toward the cost of your coverage. In any case, your coverage would end at the expiration of the period covered by your last contribution.

Coverage of an enrolled child ceases at the end of the month when the child attains the age limit shown in the Eligibility section. Coverage of a disabled child over age 26 ceases if the child is found to be no longer totally or permanently disabled.

Continuation of Coverage (Federal Law-COBRA)

If your coverage ends under the Plan, you may be entitled to elect continuation coverage in accordance with federal law. If your employer normally employs 20 or more people, and your employment is terminated for any reason other than gross misconduct you may elect from 18-36 months of continuation benefits. You should contact your Employer if you have any questions about your COBRA rights.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your group coverage would otherwise end because of certain “qualifying events.” 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 covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of your family who is enrolled in the company’s employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<p><u>For Employees:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked</p>	18 months
<p><u>For Spouses/ Dependents:</u> A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked</p> <p>Covered Employee's Entitlement to Medicare</p> <p>Divorce or Legal Separation</p> <p>Death of a Covered Employee</p>	<p>18 months</p> <p>36 months</p> <p>36 months</p> <p>36 months</p>
<p><u>For Dependents:</u> Loss of Dependent Child Status</p>	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your Spouse and children can last up to 36 months after the date of Medicare entitlement.)

Second qualifying event

If Your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Spouse or dependent children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Claims Administrator in such a situation.

Notification Requirements

In the event of your termination, lay-off, reduction in work hours or Medicare entitlement, your Employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of Your divorce, legal separation or the failure of your enrolled Dependents to meet the program's definition of Dependent. **This notice must be provided in writing to the Plan Administrator.** Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, you or an eligible family member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for employees with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. You must provide the SSA determination of your disability to the Employer within 60 days of receipt. The disability has 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. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Employer of that fact within 30 days after SSA's determination.

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

When COBRA Coverage Ends

These benefits are available without proof of insurability and coverage will end on the earliest of the following:

- a covered individual reaches the end of the maximum coverage period;
- a covered individual fails to pay a required Premium on time;
- a covered individual becomes covered under any other group health plan after electing COBRA;
- a covered individual becomes entitled to Medicare after electing COBRA; or
- the Group terminates all of its group welfare benefit plans.

Continuation of Coverage During Military Leave (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the employee (or his or her Dependents) is covered under this Plan, and if the employee becomes absent from employment by reason of military leave, the employee (or his or her Dependents) may have the right to elect to continue health coverage under the plan. In order to be eligible for coverage during the period that the employee is gone on military leave, the employee must give reasonable notice to the Employer of his or her military leave and the employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the employee and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the employee to apply for or return to work with the Employer. During military leave the employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the employee's absence is less than 31 days, the Employer must continue to pay its portion of the Premiums and the employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the employee returns to work, if the employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the employee did not elect COBRA continuation. These requirements are (i) the employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the employee upon reemployment, as well as to any

Dependent who has become covered under the Plan by reason of the employee's reinstatement of coverage.

Continuation of Coverage Due to Family and Medical Leave (FMLA)

An employee may continue membership in the Plan as provided by the Family and Medical Leave Act. An employee who has been employed at least one year, within the previous 12 months is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for the following reasons:

- The birth of the employee's child.
- The placement of a child with the employee for the purpose of adoption or foster care.
- To care for a seriously ill spouse, child or parent.
- A serious health condition rendering the employee unable to perform his or her job.

If the employee chooses to continue coverage during the leave, the employee will be given the same health care benefits that would have been provided if the employee were working, with the same premium contribution ratio. If the employee's premium for continued membership in the Plan is more than 30 days late, the Employer will send written notice to the employee. It will tell the employee that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If membership in the Plan is discontinued for non-payment of premium, the employee's coverage will be restored to the same level of benefits as those the employee would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible dependents. The employee will not be required to meet any qualification requirements imposed by the Plan when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage. Please contact your Human Resources Department for state specific Family and Medical Leave Act information.

For More Information

This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under this Plan is available from the Plan Administrator.

If you have any questions concerning the information in this notice or your rights to coverage, you should contact your Employer.

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 U.S Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website at www.dol.gov/ebsa.

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.

The Claims Administrator may inform you that a service you received is not a Covered Service under the Plan. You may appeal this decision. See the “**Member Appeals**” section of this Benefit Booklet.

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

Out-of-Network Services and Benefits

Services that are not obtained from a Network Provider will be considered an Out-of-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 an Out-of-Network Provider.

Relationship of Parties (Claims Administrator - Network Providers)

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

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 other Providers, including Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Claims Administrator.

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. The Plan 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.

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 Benefit Booklet. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Out-of-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
- Standard Eyeglass Lenses
- Frames
- Contacts Lenses in lieu of Eyeglass Lenses

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

If you choose a frame that is valued at more than the Maximum Allowable Amount you are responsible for the difference in cost.

If a Member elects covered Contact Lenses within one 12-month period, no benefits will be paid for covered lenses and frames until the next 12-month period

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.

Eyeglass Lenses

Eyeglass lenses are available in standard or basic plastic (CR39) lenses including single vision, bifocal, and trifocal. If you choose progressive lenses that are no line bifocals, there will be an additional cost. All eyeglass lenses are subject to the applicable Copayment listed in the “**Schedule of Benefits**.” There may also be an additional cost for any add-ons to the lenses such as anti-reflective coating or ultra-violet coating. These and any other lens add-ons may be discounted according to our Additional Savings Program.

Frames

The frame allowance is based upon the retail cost. The Member may apply the plan allowance toward the Network Provider’s selection of frames. The “**Schedule of Benefits**” lists the frame allowance available under your plan. If you choose a frame that is valued at more than the Maximum Allowable Amount you are responsible for the balance based upon the Additional Savings Program.

Elective Contact Lenses

The contact lens allowance must be completely used at the time of initial service. No amount of the allowance may be carried forward to use during another service date. The “**Schedule of Benefits**” lists the contact lens allowance available under the Plan.

Non-Elective Contact Lenses

This benefit is available for a limited number of diagnoses and is in lieu of the standard contact lens or Lenses and frames benefit.

Eligibility

Conditions that provide eligibility for consideration of this Non-Elective Contact Lens benefit include:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle Lenses.
- High Ametropia exceeding –12 D or +9 D in spherical equivalent.
- Anisometropia of 3 D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle Lenses.

SPECIAL NOTE: The Plan will not reimburse for Non-Elective Contact Lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Low Vision Services

The Plan's Low Vision benefits include low vision exams with supplemental testing and low vision optical or non-optical aids for severely visually impaired Members when using a Network Provider, and are **in lieu of standard exam and materials benefits**. These Members may be represented by children whose visual impairment includes the inability to read standard-sized printed material, chalkboards or computers. They may also be adults who are concerned with employment, maintaining an independent lifestyle or social interaction.

Eligibility for Low Vision Services

Members may be considered for Low Vision benefits through a Network Provider when the following eligible conditions are present:

- The best corrected acuity is 20/200 or less in the better eye, or
- There can be demonstrated a constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point or the widest diameter subtends an angle less than 20 degrees in the better eye.

Low Vision Benefits

Benefits for Covered Services are subject to any Copayment/Coinsurance and maximums listed in the Schedule of Benefits. Covered Services for Low Vision include:

- Comprehensive Low Vision exam
- Optical/Non-optical aids
- Supplemental testing each 12 month period.
- Any supplemental testing is considered part of the Optical/Non-optical aids total maximum allowance.

SPECIAL NOTE: Supplemental testing includes, but is not limited to: Automated Visual Fields, Contrast Sensitivity testing, Glare testing, Color Vision testing, Visually Evoked Potential (VEP) testing

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

- Coated lenses
- Frames that exceed the Maximum Allowable Amount
- Cosmetic Spectacle Lenses
- Ultra-violet coating
- Scratch resistant coating
- Anti-reflective coating
- Optional cosmetic items

EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service or supply would otherwise be considered Medically Necessary. 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.

The Plan does 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 Benefit Booklet.
2. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' 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 the 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 Benefit Booklet.
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. 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 Benefit Booklet.
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.

CLAIMS PAYMENT

Obtaining Services/Claim Payment

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

- The name, address and phone number of the Out-of-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
P.O. BOX 8504
Mason, OH 45040-7111

Assignment

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

Member Notice of Claim

This provision is applicable when the Member submits a claim. The Plan is not liable unless the Claims Administrator receives 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 the Claims Administrator by you within 90 days of receiving the Covered Services, and must have the data the Claims Administrator needs to determine benefits. Failure by you to give the Claims Administrator 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 by you later than one year after the usual 90 day filing period ends. If the notice submitted does not include sufficient data the Claims Administrator needs to process the claim, then the necessary data must be submitted to the Claims Administrator 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 the Claims Administrator or contact customer service and ask for claim forms to be sent to you. If you do not receive the forms, written notice of services rendered may be submitted to the Claims Administrator 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

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, Workers' 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 receive. The EOB is not a bill, but a statement from the Plan 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.

GENERAL PROVISIONS

Entire Agreement

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

Form or Content of Benefit Booklet

No agent or employee of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

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 the Plan 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 the Plan 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

This Plan is primary in all circumstances.

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.

Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider. In the event the Plan recovers a payment made in error from the Provider, except in cases of fraud, the Plan will only recover such payment from the Provider during the 24 months after the date

payment was made on a claim submitted by the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Claims Administrator 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. The Claims Administrator has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. The Claims Administrator will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Claims Administrator may not provide you with notice of overpayments made by the Plan or you if the recovery method makes providing such notice administratively burdensome.

Relationship of Parties (Employer-Member-Plan)

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

The Employer is responsible for passing information to the Member. It is the Employer'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 Employer fails to provide the Plan with timely notification of Member enrollments or terminations.

Transfer of Benefits

Only you, the Subscriber, and your Dependents, as shown on the Claims Administrator's records, are entitled to plan benefits. These rights are forfeited if you or any of your Dependents:

1. Transfer those rights; or
2. Aid any person in fraudulently obtaining plan benefits.

You and your Dependents must reimburse the Plan for any benefits paid in this context.

Conformity with Law

Any provision of this Plan which is in conflict with federal law is hereby automatically amended to conform with the minimum requirements of such laws.

Modifications

This Benefit Booklet allows the Employer to make Plan coverage available to eligible Members. However, this Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Administrative Services Agreement, or by mutual agreement between the Employer and the Claims Administrator without the permission or involvement of any Member. Changes will not be made effective until the date specified in the written notice the Claims Administrator provides to the Employer about the change. By electing vision

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 Benefit Booklet.

Clerical Error

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

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Benefit Booklet, 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 Employer may, at its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if it is determined 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 Claims Administrator shall have all powers necessary or appropriate to enable it to carry out its duties in connection with the administration of the Plan and the interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement to determine all questions arising under the Plan, to resolve Member appeals and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. The Claims Administrator has complete discretion to interpret the Benefit Booklet. The Claims Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are covered. The Claims Administrator's decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable Member appeal procedures.

Note

The Employer, on behalf of itself and its Members, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between the Employer and 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 the Administrative Services Agreement or this Benefit Booklet.

YOUR RIGHT TO APPEAL

The Claims Administrator's customer service representatives are specially trained to answer your questions about vision benefit plans. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Reimbursement amounts;
- Specific claims or services you have received;
- Provider is 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 or coverage cancellations. If you have a complaint or problem concerning benefits or services, please contact the Claims Administrator. 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 the Claims Administrator, you will be advised of your right to an internal appeal.

A Coverage Denial means the Claims Administrator's determination that a service, treatment, drug or device is specifically limited or excluded under this Plan.

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 the Plan's written notice of a Coverage Denial, or any other adverse decision made by the Claims Administrator, 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, the Claims Administrator must obtain a signed Designation of Representation (DOR) form from the Member. The appeal process will not begin until the Claims Administrator has received the properly completed DOR. The Plan 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, the Claims Administrator 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 state 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

The Plan is not liable for the furnishing of Covered Services, but merely for the payment of them. You shall have no claim against the Plan for acts or omissions of any Provider from whom you receive Covered Services. The Plan has 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 the Claims Administrator receives 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.

The Anthem National Accounts business unit serves members of the Blue Cross licensee for California; the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as Anthem BlueCross BlueShield in 17 eastern and southeastern counties, including the 5 New York City counties, and as Anthem BlueCross in 11 upstate counties), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), and Wisconsin. Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. (serving Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123.) In most of Missouri: RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation ("CompCare") underwrites or administers the HMO policies; and CompCare and BCBSWi collectively underwrite or administer the POS policies. Blue Cross Blue Shield of Georgia and Blue Cross Blue Shield Healthcare Plan of Georgia, Blue Cross of California and BC Life & Health Insurance Company, In New York: Anthem BlueCross BlueShield is the trade name of Anthem HealthChoice Assurance, Inc and Anthem BlueCross BlueShield HMO is the trade name of Anthem HealthChoice HMO, Inc. Independent licensees of the Blue Cross Blue Shield Association. ® ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.