A Guide to Your Benefits

You've made a good decision in choosing
Blue View Vision Buy-Up Plan

Independent licensees of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks of Blue Cross and Blue Shield Association.

Blue View Vision
Schedule of Benefits

This schedule is an outline of your benefits. You need to refer to the entire booklet for complete information about the benefits, conditions, limitations and exclusions of your plan.

Vision Care Services	Benefit Frequency	In-Network	Out-of-Network
Eye Exam (with dilation as necessary)	Once every 12 months*	$30 copay	Up to $35
Standard Plastic Lenses†	Once every 24 months*		
Single Vision		$30 copay	Up to $25
Bifocal		$30 copay	Up to $40
Trifocal		$30 copay	Up to $55
† Lenses include factory scratch coating at no additional cost. Polycarbonate and photochromic lenses are covered for dependent children under 19 with no additional cost.]			
Contact Lenses	Once every 24 months*		
Elective (conventional and disposable)		$130 allowance	Up to $80
Non-Elective		covered in full	Up to $210
Frames	Once every 24 months*	$130 allowance	Up to $45

*From last date of service

Anthem Blue Cross and Blue Shield
Blue View Vision Member Booklet

Welcome!

Thank you for choosing Anthem Blue Cross and Blue Shield (Anthem) for your vision care coverage.

The following materials are part of the terms of your coverage:

- this booklet
- your application
- any amendments the Employer Master Application
- the Employer Master Contract or Administrative Services Agreement

This booklet contains important information such as what vision care services are covered and how they will be covered. It replaces any older booklets issued to you for your vision plan.

We, or someone acting on our behalf, will generally determine how benefits will be administered and who is eligible for participation in a manner consistent with the terms of this Booklet. If any question arises about the interpretation of any provision of this Booklet, Our determination will be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/Investigational, or cosmetic. However, you may utilize all applicable Complaint, Grievance and Appeal procedures available under this Booklet.

Within the booklet the insured person is referred to as “you” or “your”. Anthem Blue Cross and Blue Shield is referred to as “we,” “us” or “our.” All italicized words are defined in the “Definitions” section of this booklet.

Please review this booklet so you know where to find the information that you may need. Store it in a convenient place and refer to it whenever you have questions about your vision care coverage or how We administer it on behalf of your employer.

Mike Ramseier
President & General Manager
Anthem Blue Cross and Blue Shield

Important Note: There are currently no participating vision providers available in Baca, Bent, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Dolores, Gilpin, Grand, Hinsdale, Jackson, Kiowa, Kit Carson, Lake, Mineral, Moffat, Montezuma, Morgan, Ouray, Park, Phillips, Pitkin, Rio Blanco, Routt, Saguache, San Juan, San Miguel, Sedgwick, Washington, Yuma.

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Contact us

Member services

Anthem Blue Cross and Blue Shield
P.O. Box 8504,
Mason, OH 45040-7111
(866) 723-0515

Visit us on-line

www.anthem.com

Hours of operation

Monday - Saturday

5:30 a.m. to 8:00 p.m. MST

Sunday

8:00 a.m. to 5:00 p.m. MST

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Eligibility

This section explains when your coverage begins and who is eligible for coverage. It also explains your effective date and where to find that information. Keep reading this section to learn about eligibility requirements and your effective date. Refer to the “Termination / Nonrenewal” section for how your coverage ends.

Who is Eligible for Coverage

Your Eligible Dependents

You (the *subscriber*) have coverage under this booklet because of your employer. You may enroll your eligible *dependent*s for coverage under this *plan*. Your *dependent*s are only eligible for coverage if they are one of the following:

- **Spouse:** Your spouse under a legally valid marriage or a common-law spouse.
- **Partner in a Civil Union.** All references to spouse in this Benefits Booklet include a partner in a civil union except a partner in a civil union is not eligible for COBRA coverage. There may be tax consequences to the Subscriber when enrolling his or her partner in a civil union and his or her partner’s child. However a partner in a civil union and children of a partner in a civil union are eligible through the employer for continuation of coverage under the same time conditions and time periods as COBRA. Contact your employer for eligibility requirements.
- **Common-Law Spouse**. All references to spouse in this Benefits Booklet include a Common-Law Spouse. Contact your employer for eligibility requirements.
- **Same Gender Domestic Partner (SGDP).** All references to spouse in this Benefits Booklet include a SGDP except a SGDP is not eligible for COBRA coverage. There may be tax consequences to the Subscriber when enrolling his or her SGDP and his or her SGDP’s child. However a SGDP and children of a SGDP are eligible through the employer for continuation of coverage under the same time conditions and time periods as COBRA. Contact your employer for eligibility requirements.
- **Child:** Yours’, your spouse’s, or your domestic partner’s child, stepchild, or legally adopted child that is under 26 years of age.
  - If the unmarried child is disabled they may continue to be covered under this *plan* if we receive notice of the disability. You and the child’s physician must fill out a disabled dependent form and provide it to us. Contact us to obtain the form.

Newborn and Adopted Dependent Coverage

We provide automatic coverage to a newborn *child* or an adopted *child* (under 18 years of age) for 31 days. For a newborn *child* coverage begins on the date of birth. For an adopted child coverage begins on the date you assume or retain a legal obligation to support the *child*.

You must add the newborn *child* or adopted *child* to your *plan* within 31 days for coverage to continue beyond 31 days. You must contact us to obtain the necessary forms.

Notice of Changes in Eligibility

You must tell your employer and us if there are any changes that will affect your or your *dependent*’s eligibility. You must notify us within 31 days of any event that changes your or your *dependent*s eligibility. This includes a change in address, a marriage, or a divorce. If you do not tell us about a change in eligibility, it does not obligate us to pay for vision care.

How to Enroll Your Dependents for Coverage

Open Enrollment

At least once a year your employer will hold an open enrollment period. During the open enrollment period your eligible *dependent*s can enroll for coverage.

Special Enrollment

There may be times when your *dependent*s can enroll for coverage outside of the open enrollment period. We allow this when there is a change in a dependent status, a court order, or an involuntary loss of other group coverage.

Involuntary Loss of Other Group Coverage

If your *dependent*s did not enroll during open enrollment because of other group coverage, they may enroll when that coverage ends. You or your *dependent*s must tell us that they want to enroll within 31 days after the other group coverage ends.

Change in Dependent Status

If you have a new *dependent* due to a qualifying event, you may enroll your *dependent* for coverage. A qualifying event is marriage, the birth of a child, or a child placed for adoption. You must enroll your *dependent* within 31 days of the qualifying event.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or other court order to provide coverage to a child, you can enroll the child at any time. You do not have to wait until your employer's open enrollment period.

Your Effective Date

Your coverage begins on your effective date. This is the date we and your employer agreed that your coverage would start. We will strive to mail your welcome letter and ID card to you before your coverage starts. Your effective date will be listed on your welcome letter and will also be printed on your ID card.

How to Access Your Services and Obtain Approval of Benefits

Please read the following information so you will know from whom or what group of providers vision care may be obtained.

> **Important Note:** Neither We nor your employer restrict or interfere with your right to select the provider of your choice, but your benefits are reduced when you use a provider who is not a *participating provider*.

Participating and Non-Participating Providers

Participating Providers

We have a network of *participating providers* for you to use. We call them “participating" vision care providers because they have agreed to take part in our network. They have agreed to provide *covered services* to you for a negotiated rate. Covered Services you receive from a participating provider are considered In-Network care.

Non-Participating Providers

Non-participating providers are vision care providers that did not agree to participate in our network. They have not agreed to a negotiated rate and do not have a provider contract with us. Using a *non-participating provider* will typically increase your out of pocket costs. Covered Services you receive from a non-participating provider are considered Out-of-Network care.

Please call us or visit our website for help in finding a *participating provider*.

Benefits / Coverage

Benefit Maximums and Allowances

The amount we pay, on behalf of your employer, for your benefits is subject to your benefit maximums and allowances. We and your employer will not pay for vision care services that go over your benefit maximums or allowances as stated in the schedule of benefits.

Conditions of Service

The following conditions of service must be met for vision care services to be considered a *covered service*.

1. You must receive vision care while you are covered for benefits under this *plan*. Vision care is incurred on the date you receive the service for which the charge is made.
2. The vision care must be provided by a licensed optometrist, ophthalmologist, or optician.
3. The vision care must be for a vision service that is included under "Vision Care That is Covered".
4. The vision care must not be for a service or supply listed under "Vision Care That is NOT Covered". If the service or supply is partially excluded, then only that portion which is not excluded will be considered a *covered service*.
5. The vision care must not exceed any of the benefits maximums, allowances or limitations of this *plan*.

Vision Care That is Covered

The following services or supplies are covered subject to our Conditions of Service. We, on behalf of the employer, will only pay for vision care that is listed in this section. We will not pay for vision care listed in the "Vision Care that is not Covered" section.

Eye Exam

Your plan covers a complete eye exam with dilation as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together. An eye exam does not include a contact lens fitting fee.

Eyeglass Lenses

You have a choice in your eyeglass lenses. Lenses include factory scratch coating at no additional cost. Your dependent children under 19 may also receive polycarbonate and photochromic lenses at no additional cost.

Covered eyeglass lenses include plastic (CR39) lenses up to 55 mm in:

- single vision
- bifocal
- trifocal (FT 25-28)

*Frames**

You have a benefit allowance towards your choice of frames. You may apply the allowance toward the purchase of any frame. If your frame choice is more than your allowance, then you are responsible for the balance. The Schedule of Benefits lists your allowance and benefit frequency.

*Elective Contact Lenses**

Elective contact lenses are contacts that you choose instead of eyeglasses comfort or appearance. You may choose elective contact lenses in lieu of your eyeglass lenses benefit.

*Non-Elective Contact Lenses**

Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent.
- Anisometropia of 3D 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.

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses and frames until you satisfy the benefit frequency listed in the Schedule of Benefits.

SPECIAL NOTE: Neither We nor the employer will 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.

Limitations / Exclusions

Vision Care That is NOT Covered

We, on behalf of the employer, will not pay for services incurred for, or in connection with, any of the items below.

- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a member receives the benefits in whole or in part. This exclusion also applies whether or not the member claims the benefits or compensation. It also applies whether or not the member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the member's immediate family, including the member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Booklet or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a network provider).
- For sunglasses and accompanying frames.
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Booklet.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

Member Payment Responsibility

This section tells you how we set the payment amount for vision care and also what your cost share is. Our payment on behalf of the employer for vision care to *participating* and *non-participating providers* is based on our *maximum allowable amount*. Your cost share will differ depending on your choice of vision care provider.

The Maximum Allowable Amount

The *maximum allowable amount* is the maximum amount we pay for covered services. It is based on our established network fee schedule.

In-Network
For covered services received In-Network, the maximum allowable amount is equal to the network provider's agreement for this product.

Out-of-Network
For covered services received Out-of-Network, the maximum allowable amount is the lesser of the actual charge or the rate under the network provider's agreement for this product. We will pay up to the amount listed in the schedule of benefits.

Your Cost Share Requirements

Your Cost Share

You may be required to pay a part of the *maximum allowable amount* for *covered services*. This is called your cost share amount. *Copays* or *deductibles* are examples of a cost share amount.

Your cost share amount will vary depending on whether you receive vision care from a *participating* or *non-participating provider*. You may be required to pay higher cost sharing amounts when using *non-participating providers*.

We will not provide payment for vision care that is not covered by your *plan*. You are required to pay all charges for vision care that is not covered. Vision care received after you have met benefit maximums is also not covered.

Authorized Services

In some situations, we may authorize the participating cost share amounts to apply to vision care received from a *non-participating provider*. We may allow this if there is no *participating provider* available for you to receive vision care. You must contact us before you receive your vision care.

If during an emergency you receive vision care from a *non-participating provider*, the participating cost share amount may even apply if you do not contact us in advance.

If we authorize the participating cost share for vision care from a *non-participating provider*, you are still responsible for the difference between our *maximum allowable amount* and the billed amount.

Claims Procedure

You are responsible for getting claims filed after you receive vision care. However, if you receive vision care from a *participating provider* they will typically file claims on your behalf.

If you receive care from a *non-participating provider* you must submit the claim to us

After you receive vision care you will need to contact us, either by phone or mail, within 20 days of your vision care so we can provide you claim forms for filing. If you are unable to contact us within 20 days, you should contact us as soon as possible. We will provide claim forms within 15 days for you to file. The claim form will have instructions on how to fill it out and where to mail it.

We must receive the claim form within 90 days from the date you had your vision care. If you are not able to send the claim within 90 days we will not void or reduce your claim. However, you must send it as soon as possible, and in no event no later than a year from when it was due unless you are legally incapacitated.

If you do not receive a claim form within 15 days after you request one, you may send us an itemized bill instead. The itemized bill must include all of the following:

- the date of service;
- the patient's name, date of birth, and identification number;
- the type and place of service;
- your signature and the *provider's* signature.

Please send claims and itemized bills to the following address:

Anthem Blue Cross and Blue Shield
P.O. Box 8504,
Mason, OH 45040-7111

General Provisions

Fraudulent Insurance Acts: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a subscriber or claimant for the purpose of defrauding or attempting to defraud the subscriber or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Entire contract - changes: Your *plan* is the entire contract of insurance. Your *plan* is made up of any attached paper and any amendments that we issue. An executive officer must endorse any change that we issue for it to be valid. No agent has authority to change this *plan* or to waive any of its provisions.

Time of payment of claims: We will pay claims promptly once we receive written proof of your claim as outlined under our claims procedure.

Payment of claims: We will pay claims directly to providers if they have an assignment of benefits on file. If the provider does not have an assignment of benefits on file then we will pay claims to you. If you pass away, we will pay claims to your designated beneficiary or to your estate if there is no assignment of benefits.

Physical examinations: We may have you examined as reasonably needed while we are deciding to pay a claim.

Change of beneficiary: You have the right to choose your own beneficiary.

Independent Contractors: Providers are not our agents or employees. They do not have the ability to waive or alter your *plan*. We are not responsible for any damages or injuries as a result of receiving care from them.

Right of Recovery: When we, on behalf of the employer, overpay a claim, we have the right to recover our overpayment. We may recover our overpayment from you, the person we paid, or another plan.

Benefits not Transferable: You are the only person able to receive benefits under this *plan*. You are not able to transfer your benefits to anyone else.

Continuation of Care: If a *participating provider's* contract terminates with us, we shall continue to pay for covered services received from that provider for 60 days if you are under their care. The provider will also provide you care for 60 days in accordance with this *plan* unless your care is assumed by another *participating provider*.

Contracting Entity: You acknowledge that you understand that the *plan* constitutes a contract solely between you and your employer. We are an independent corporation operating under a license from the Blue Cross and Blue Shield Association, which is an association of independent Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield Service Mark, and in doing so, we are not contracting as the agent of the Blue Cross and Blue Shield Association. You further acknowledge and agree that you have not entered into the contract based on representations by any person other than one of our representatives, and that no person, entity or organization other than your employer will be held accountable or liable to you for any obligations created under the booklet. This paragraph does not create any additional obligations whatsoever on our part other than those obligations created under other provisions of the booklet.

The Plan, on behalf of the employer, 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.

Neither the Plan nor your employer is responsible for the actual care you receive from any person. This Benefit Booklet does not give anyone any claim, right, or cause of action against the Plan or your employer based on what a Provider of vision care, services or supplies, does or does not do.

Coordination of Benefits: We consider this *plan* primary in all circumstances.

Statement of ERISA Rights

Your group plan may be part of an employee welfare benefit plan governed by the Employee Retirement Income Security Act (ERISA). If your group plan is governed by ERISA, then you are entitled to the following:

- Your group must allow you to see all documents that govern this plan. This includes a copy of the latest annual report that we filed with the U.S. Department of Labor. You can view these documents at no charge at your group office or some other location that you and the group agree to;
- You can, through a written request to your group, get copies of the documents that govern this plan. This includes copies of the latest annual report and an updated summary plan description. Your group may charge you a reasonable fee for the copies; and,
- Your group is required by law to give each member a copy of the summary annual report

ERISA also makes rules for the people who are responsible for the operations of your plan. These people are called "fiduciaries" of the plan. They have a duty to operate this plan in a reasonable way that is in your interest. No one, including your employer, can fire you or discriminate against you, to prevent you from getting a welfare benefit. Also, they cannot prevent you from using your rights under ERISA.

If you submit a claim and it is denied or ignored, you have a right to know why. You have a right to get copies of the documents that relate to the decision in your claim. These documents must be provided to you at no charge. You also have the right to appeal the decision in your claim. To make an appeal, you must follow the process that is stated in the “Appeals and Complaints” section.

Under ERISA, there are steps you can take to enforce your rights. For example, if you ask for a copy of plan documents or the latest annual report and the group does not give them you within 30 days, you may file suit in a Federal court. The court may require the group to give you the documents and pay you up to $110 a day until you receive the documents. If you have a claim that was denied or ignored, you may file suit in a state or Federal court. However, you can only file suit after you have gone through the appeals and complaints process in this booklet. If the plan fiduciaries misuse the plan's money, or if you are discriminated against because you have enforced your ERISA rights, you should contact the U.S. Department of Labor. You may also file suit in a Federal court. If you file suit, the court will decide who should pay court costs and legal fees. If you win your case, the court may order the other party (or parties) to pay these costs and fees. If you do not win your case, the court may order you to pay the costs and fees.

Questions about ERISA

If you have any questions about your plan and whether or not the ERISA rules apply to your plan, contact your group. If you have any questions about your ERISA rights or if you need help getting documents from your group, contact the nearest office of the Pension and Welfare Benefits Administration. The Pension and Welfare Benefits Administration is a part of the U.S. Department of Labor. They are listed in the phone directory. You can also contact them at the following address:

Division of Technical Assistance and Inquiries
Pension and Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210.

You can also get more information about ERISA rights and responsibilities by calling the publications hotline of the Pension and Welfare Benefits Administration.

We give the group or other fiduciaries the authority to determine eligibility for coverage. The group or other fiduciaries also have the authority to interpret the terms of this plan. The group and other fiduciaries must do these things in a reasonable way and within the limits of any state or federal laws.

Termination / Nonrenewal / Continuation

This section explains how your coverage may end and your rights regarding reinstatement. Keep reading this section to learn about how your coverage may end. Refer to the “Eligibility” section for your dependent eligibility requirements.

If Your Employer Cancels Coverage

Your coverage will end if your employer cancels coverage or on the date the Employer Master Agreement or Administrative Services Agreement between us and your employer ends.

If You Cancel Your Coverage

If you want to cancel your or your *dependent’s* coverage you need to tell us in writing. You may provide the date you would like to cancel your coverage. If you do not provide a cancellation date we will cancel your *plan* on the first day of the next month. We will send you notice of your cancellation date and refund any unused premium.

Upon the Subscriber’s Death

If the *subscriber* dies, coverage under this *plan* will end. *Dependents* may seek coverage under COBRA.

If Your Employer Does Not Pay the Premium

We must receive the premium no later than the end of the grace period for your coverage to remain in force. If your employer does not pay your premium by the end of your grace period we may cancel your coverage.

If You or Your Dependents are no Longer Eligible

Your (the *subscriber’s*) coverage ends when you no longer meet the terms of the Employer Master Contract or Administrative Services Agreement. Your coverage will end on the first on the month following loss of eligibility.

Your *dependents* coverage will end when they no longer meet the definition of a *dependent*. We will cancel your *dependent’s* coverage on the first of the month following the date they lose eligibility. You may also request to remove a *dependent* from your *plan*.

Mistakes and Fraudulent Misstatements

If you or your employer made mistakes on your application we may void your *plan* or deny claims if we discover it during the first two years of your coverage. We will not void your *plan* or deny claims for mistakes we discover after two years.

If you or your employer made fraudulent misstatements on your application we may void this *plan* or deny claims at any time.

Fraud

If you or your *dependents* knowingly engage in any fraud or misuse of the benefits in this booklet, we will cancel your coverage.

Non-Renewal of Your Plan

We may at any time decide to not renew this *plan*. If this happens we will give you 90 days notice before we non-renew this *plan*.

We Cease to Operate

If we cease operations we will cancel your coverage. We will continue to provide coverage for the rest of the period in which premiums were paid.

Reinstatement of Your Plan

If your *plan* was canceled because you did not pay your premium within the grace period you may have it reinstated. Your *plan* will be reinstated if we accept your premium payment after we have canceled your *plan*. If we accept your premium we will not require an application to reinstate your *plan*.

However, we may ask for a new application to accept your premium and reinstate your *plan*. If we ask for a new application we will only re-instate your *plan* after we approve your application. We will notify you if we do not approve of your application within 45 days. If we do not notify you within 45 after we received your application, it will be deemed approved.

If your *plan* is reinstated, only vision care received after the reinstated date will be covered. Your rights will be the same and will not change due to the reinstatement. We will apply the reinstated premium to the period for which the premium was not paid. However, we will not apply premium to any period over 60 days prior to reinstatement.

United States Military Reserve and National Guard

If you stop your coverage because you are called to active duty, then you may have you coverage reinstated once your active duty is over. Your coverage will be reinstated without any waiting periods. Contact us for info on how to restart your coverage once you end active duty.

How to Continue Coverage

State Continuation

Your employer is subject to the state continuation law if they have less than 20 employees. This law allows you and your dependents to continue coverage for up to 18 months for the following events:

- You (the subscriber) are terminated or have a reduction in working hours resulting in loss of coverage. You must have been covered by the employer’s vision insurance for at least 6 consecutive months to qualify.
- Your (the subscriber’s) death.
- You and your spouse divorce or become legally separated.
- Your dependents lose coverage under this plan.

You must notify your employer within 30 days if you or your dependents wish to continue coverage after an event. Once notified, your employer will provide the information on how coverage may continue, and

must give us notice within 30 days of the event that you wish to continue coverage. Contact your employer for more information.

COBRA Continuation

Your employer is subject to COBRA if they have more than 20 employees. COBRA allows you and your dependents to continue coverage for either 18, 29 or 36 months depending on the event.

COBRA coverage is available to you and your dependents for 18 months for the following events:

- You lose coverage due to a reduction in working hours, a layoff, or strike.
- You lose coverage because your employment ends. (For voluntary or involuntary loss, except for gross misconduct).

COBRA coverage is available to you and your dependents for 29 months for the following events:

- You or your dependent was disabled when coverage ended or within 60 days after the coverage ended. However, you or your dependent must continue to be disabled after 18 months has passed. The Social Security Administration must determine if you are disabled.

COBRA coverage is available to your dependents for 36 months for the following events:

- Your death.
- You become eligible for Medicare in the 18 months before an event listed above.
- You divorce or separate from your spouse.
- Your dependent children no longer qualify as dependents.

You must notify your employer within 60 days if you or your dependents wish to continue coverage under COBRA after an event. Once notified, your employer will provide the information on how coverage under COBRA may continue, and must give us notice within 30 days of the event that you wish to continue coverage. Contact your employer for more information.

How State Continuation or COBRA Ends

Your state or COBRA continuation coverage ends when the time period that you qualified for runs out. However, coverage may end before that time if one of the following occurs:

- The Employer Master Contract or Administrative Services Agreement between us and the employer ends. If your employer switches coverage you will be able to continue coverage under their new plan.
- You fail to pay the premium.
- You tell us in writing to cancel your coverage.
- The date your spouse remarries and becomes eligible under the new spouse's plan.

Coverage may also end for State Continuation if the following occurs:

- You are eligible for coverage with another group. However, if your State Continuation plan covers something that the other group doesn't then you may continue coverage. Your coverage will continue until the group covers that exclusion or you are no longer eligible.

Coverage may also end for COBRA if the following occurs:

- You are eligible for coverage with another group. However, if your COBRA plan covers something that the other group doesn't then you may continue coverage. Your coverage will continue until the group covers that exclusion or you are no longer eligible.
- You get Medicare
- Your coverage was extended to 29 months and you are now no longer disabled.

Conversion Coverage

Conversion is not available under this Booklet.

Military Service

If you are going into or coming back from military service, you and your dependents may continue coverage under this plan. These rights apply only if you and your dependents were covered under this plan before you leave for military service.

If you keep this coverage for you or your dependents, you may be asked to pay up to 102% of your normal premium. But if you are on active duty for 30 days or less, you cannot be asked to pay more than your normal premium.

The maximum time of coverage under this provision is the lesser of:

- 24 months, starting on the date when your absence from work begins; or
- Until you return to work. If you do not return to work, your coverage will end the day after you were supposed to apply for or return to work.

When you return to work there will not be any limits or waiting periods to reinstate your coverage, as long as there were none before your military service. But there may be limits or waiting periods if you have any illness or injury that the Secretary of Veterans Affairs finds to have been as a result of your service.

Appeals and Complaints

We may have turned down your claim. We may have also denied your request to preauthorize a service. If you disagree with our decision you can:

1. start a complaint
2. file an appeal or
3. file a grievance.

Complaints

If you want to start a complaint about our customer service or how we processed your claim, please call us. A trained staff member will try to clear up any confusion about the matter. They will also try to resolve your complaint. If you prefer, you can send a written complaint to this address:

Anthem Blue Cross and Blue Shield
P.O. Box 8504,
Mason, OH 45040-7111

If your complaint isn't solved either by writing or calling, or if you don't want to file a complaint, you can file an appeal. We'll tell you how to do that next, in the Appeals section.

Appeals

It's best to file your appeal within 60 days of getting a denial. The absolute cut-off date for filing an appeal is 180 days from the day you were denied. You can appeal denials that were made either before you received service or after you received service. You can send an appeal in writing to:

Anthem Blue Cross and Blue Shield
P.O. Box 8504,
Mason, OH 45040-7111

You don't have to start a complaint before you file an appeal. In your appeal, please state as plainly as possible why you think we shouldn't have denied your claim. Include any documents you didn't submit with the original claim or service/supply request. Also send any other document or documents that support your appeal.

To make sure you get a thorough, unbiased appeal, there are two levels of appeal. Also, if your claim was denied because of utilization review, you may request independent external review.

You don't have to file the appeal yourself. Someone else, like your doctor, can file any level of appeal for you. Just let us know in writing who will be filing the appeal for you.

Level 1 appeal

A Level 1 appeal will be reviewed by a person, who may be on our staff, but who wasn't involved in the denial. They may get information from co-workers or others who did make the decision. Where the decision is based on utilization review, the Level 1 appeal will involve a review by (or a discussion with) a person in the same medical specialty as the case being reviewed.

Unless you ask for or agree to a longer period, you'll get an answer to your appeal within 30 days from when we got your appeal request. But for appeals of services that were already performed, and which did not involve a denial based on utilization review, we'll answer the appeal in 60 days.

Level 2 appeal

If we turned down your appeal at Level 1 you have the choice to continue to a Level 2 appeal. You have 60 days from our Level 1 decision to ask for a Level 2 appeal.

A Level 2 appeal gives you the chance to supply documents or information at an appeal hearing. You can do this in a couple of ways. You can come in person or you can use a teleconference. You are encouraged to bring information, testimony, witnesses or other evidence that supports your appeal.

There will be at least three people who review your appeal. They could be our employees. People who worked on your claim may present information, answer questions, or review the appeal. But a majority of the reviewers will not have worked on your claim before.

If your case involves utilization review, the people reviewing your appeal will be health care professionals. All reviewers:

- Will have appropriate expertise
- Will not have been previously involved in your case; and
- Will not be on our board of directors.
- Will not have a direct financial interest in the case or in the decision.

We will give you a copy of our written decision. We'll also give a copy to any provider who may have represented you in the appeal. You'll get the copy within 60 days from the day we got your Level 2 request, unless you ask for or agree to a longer period.

Expedited appeals

You or your representative can ask for an expedited appeal if you had emergency services but haven't been discharged from the facility. Also, you can ask for an expedited appeal if the regular appeal schedule would do one of the following:

- Seriously jeopardize your life or health;
- Jeopardize your ability to regain maximum function;
- Create an immediate and substantial limitation on your ability to live independently, if you're disabled; or
- In the opinion of a physician with knowledge of your condition, would subject you to severe pain that can't be adequately managed without the service in question.

But expedited appeals are not available for denials made after the service has been provided.

Your request doesn't have to be in writing and can be made orally. We'll try to make the decision as soon as we can. But it won't take more than 72 hours. The reviewers won't be the people who denied your claim before. If you don't agree with the appeal decision, you can either continue to a Level 2 appeal, or request independent external review.

Independent external review appeals

For claims based on utilization review, you can request an independent external review appeal. For these appeals, your case is reviewed by an external review entity, selected by the Colorado Division of Insurance.

If you want to request an independent external review, you have to fill out a form. It's called the Request for Independent External Review of Carrier's Final Adverse Determination Form. (Your representative can fill it out for you too.) You can get the form from our customer service department. Once it's filled out, you need to send it to us.

You can ask for an independent external review within 4 months of your receipt our Level 1 appeal decision, or within 60 days from receipt of the Level 2 appeal decision, or if we fail to complete the Level 1 appeal in the timeframes mentioned above.

Expedited independent external review appeals

You can request an expedited independent external review, but only if your case meets certain criteria. You will need a physician to certify to us that you have a medical condition where following the normal external review appeal process would seriously jeopardize your life or health, would jeopardize your ability to regain maximum function or, if your disabled, would create an imminent and substantial limitation of your ability to live independently. If it meets these conditions, your request can be filed at the same time as your request for a Level 1 Appeal. Use the external review request form to request an expedited review. An expedited appeal may not be allowed for denials made after service was provided.

Grievances

You may send a written grievance to:

Anthem Blue Cross and Blue Shield
P.O. Box 8504,
Mason, OH 45040-7111

Our Member Grievances Department will acknowledge that we've received your grievance. They'll also investigate it. We treat every grievance confidentially.

Division of Insurance Inquiries

If you have a question about health care coverage in Colorado, please call the Division of Insurance at (303) 894-7490. Representatives will speak with you Monday through Friday, from 8:00 a.m. to 5:00 p.m. You can also write to:

The Division of Insurance
Attention ICARE Section
560 Broadway, Suite 850
Denver, Colorado 80202.

Binding Arbitration

If the dollar amount of your dispute with Anthem goes above the limit of Small Claims court, then your case will be decided by Binding Arbitration. If it does, you and Anthem give up the right to have the dispute decided in court.

To be arbitrated, a case must first go through all the mandatory levels of appeal and review outlined in this *Booklet*. Arbitration cases are governed by the rules of the American Arbitration Association. Disputes are governed by the laws of the state where the *Booklet* was issued and delivered to the subscriber. Arbitration rulings are binding on you and Anthem. The award can be reviewed and enforced by any court with proper jurisdiction. If anyone starts a lawsuit or other legal action, the other party may ask a court of competent jurisdiction to forbid, stop or dismiss the action and order the parties to follow the arbitration steps presented here. An arbitrator will decide whether any dispute falls under the arbitration clause.

Legal Action

Before you take legal action on a claim decision, you must first follow the complaints and appeals process as outlined in this *Booklet*. You must meet all the requirements of this *plan*. If the law requires, and if you have exhausted all mandatory levels of review as defined in this *Booklet*, you can also have the claim decision reviewed de novo (as if for the first time) in any court with jurisdiction and to a trial by jury.

No action in law or in equity shall be brought to recover on this *plan* prior to expiration of 60 calendar days after a claim has been filed in accordance with the requirements of this *plan*. No such action shall be brought at all unless brought within three years from the date proof of loss is otherwise required

Information on Plan and Premium Changes

This section explains how and for what reasons that we may change your *plan* and your premium.

Changes to Your Plan

We have the right to change any term or condition of your *plan* (including your premiums) at any time. We will provide you 30 days written notice prior to any change to your *plan*.

Changes to Your Premium

Premiums are the monthly charges you and your employer must pay us for coverage and administrative services. We determine and set out the required premiums.

Your employer is responsible for paying your premium to us according to the terms of the Employer Master Contract or Administrative Services Agreement. You may have to help pay the premium cost through payroll deduction. We may change your premiums on the renewal date of your employer. If wrong information is given to us that we use to establish your premium, then the difference will billed to the employer.

Your employer is entitled to a grace period of 31 days for the payment of such premium. During the grace period, our contract with the employer shall continue in force unless the employer gives us written notice of termination.

Definitions

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

Administrative Services Agreement — the agreement between Anthem Blue Cross and Blue Shield and the employer, regardless of how such an agreement may be titled, stating all the terms and provisions applicable to the administration of this Plan.
Benefit period – is a 12 month period starting on July 1 at 12:01 a.m. Mountain Standard Time.

Booklet – This booklet, which is a summary of your *plan's* coverage.

Copay – is a fixed dollar amount that you are responsible to pay.

Covered service – is a vision service that is listed in the benefit section of this Booklet.

Deductible – is the amount you have to pay out-of-pocket for *covered services* before we begin to pay.

Dependent – is a person of the *subscriber's* family who is eligible for coverage under the *plan* as described in the Eligibility section of this *Booklet*.

Effective date – is the date your coverage begins. Your effective date is listed on your ID card.

Non-participating provider – is a provider who has not entered into a contractual agreement with us for the network associated with this *plan*.

Participating provider – is a provider who has entered into a contractual agreement with us for the network associated with this *plan*. They also accept our payment plus your cost-share as payment in full for *covered services*.

Plan – is the entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this booklet, your application, any amendments, the Group Master Application, Administrative Services Agreement and the Employer Master Contract.

Subscriber – is the person whose enrollment application has been accepted by us for coverage under this *plan*.