Vision Certificate of Coverage

BLUE VIEW VISION

FS.A.10.10.130.130

OPEN HEALTH TRUST

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

Welcome!

Thank you for choosing Anthem Blue Cross Life and Health Insurance Company (Anthem) for your vision care coverage. The following materials make up your plan:

- this booklet;
- your application, if any; and
- any endorsements or riders.

Your employer (also referred to as your *group*) has the following documents which are part of the terms of your *plan*:

- the *group contract*; and
- the group master application.

This *certificate* contains important information such as what vision care services are covered and how they will be covered. It replaces any older certificates issued to you for this vision plan.

Within this *certificate members* are referred to as “you” or “your”. Anthem is referred to as “we,” “us” or “our.” All italicized words have special meanings that are defined in the Definitions section of this *certificate*.

Please review this *certificate* 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. See the section Contact Us for information on important phone numbers, addresses and websites.

Contact Us

If you have questions about your coverage or need assistance finding a Blue View Vision *network provider*, please contact us.

For Customer Service
Anthem Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111
(866) 723-0515

Visit us on-line
https://www.anthem.com/ca
Visit the website above to find a participating provider in your area. Once you are on the website, click on Menu and then Find a Doctor. You can search as a member using your Anthem ID card to make sure you find a network provider who accepts your plan.

Hours of Operation
Monday – Saturday:
8:30 a.m. to 11:00 p.m. Eastern Time

Sunday:
11:00 a.m. to 8:00 p.m. Eastern Time

Table of Contents

Schedule of Benefits

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

CHOICE OF VISION CARE PROVIDER: Nothing contained in this *certificate* restricts or interferes with your right to select the vision care provider of your choice, but your benefits are reduced when you use a *non-network provider*. See the section How Your Benefits Work for more information.

COVERED SERVICES	COPAYMENTS/MAXIMUMS Network Providers	 Non-Network Providers
Routine Eye Exam Limited to one exam Once every 12 months	$10 Copay	Reimbursed Up To $49
Prescription Lenses Includes factory scratch coating, polycarbonate lenses for children under 19 years old and Photochromic lenses for children under 19 years old when received from network providers. Limited to one set of lenses per member Once every 12 months*. **Basic Lenses (Pair)**		
• Single Vision lenses	$10 Copay	Reimbursed Up To $35
• Bifocal lenses	$10 Copay	Reimbursed Up To $49
• Trifocal lenses	$10 Copay	Reimbursed Up To $74
• Factory Scratch Coating	$0 Copay	Not Covered
• Polycarbonate – Pediatric (up to age 19)	$0 Copay	Not Covered
• Standard Progressive	$65 Copay	Reimbursed Up To $49
• Photochromic – Pediatric (up to age 19)	$0 Copay	Not Covered
Frame Limited to one set of frames per member Once every 12 months	$130 Allowance	Reimbursed Up To $50
Prescription Contact Lenses (traditional or disposable) **Note:** Contact lenses are in lieu of your eyeglass lens benefit. If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in this Schedule of Benefits.		
• **Elective Contact Lenses** Availability Once every 12 months*****	$130 Allowance	Reimbursed Up To $92
• **Non-Elective Contact Lenses** Availability Once every 12 months*	Covered in full	Reimbursed Up To $250

* From the last date of service

Laser Vision Correction Services
Participating LASIK/ photorefractive keratectomy (PRK) surgical centers offer a discounted rate. For *members* enrolled under this *plan*, you are responsible for any remaining charges.

Eligibility and Enrollment

Who is Eligible
This section will tell you who is eligible to enroll for coverage, as well as when you can enroll for coverage.

Subscriber. You are eligible to be a subscriber and have coverage under this *plan* if you are an employee or other member of the group of the *group* and meet the *group's* eligibility criteria. See your group for more information on specific eligibility requirements.

Dependents. You may enroll your eligible *dependents* for coverage under this *plan*. Your *dependents* are only eligible for coverage if they are one of the following:

- Spouse: Your spouse under a legally valid marriage.
- Domestic partner: Your domestic partner under a legally registered and valid domestic partnership.

Children: Your or your spouse's or domestic partner's child by blood or by law up to age 26. This includes your natural children, stepchildren, legally adopted children, children placed for adoption, foster children or children for whom you are the legal guardian or have been court-ordered to provide coverage.

Your children may continue coverage beyond the above stated age limit if:

- they are unmarried and incapable of self-support due to an intellectual disability or physical handicap;
- are financially dependent on you or your spouse or domestic partner for support and maintenance; and
- were enrolled and disabled prior to reaching the limiting age of this *plan*.

You and the child's physician must fill out a disabled dependent form and provide it to us. Contact us to obtain the form. After two years from when you initially provided proof, we may ask for continued proof of the child's disability, but no more than once a year.

Newborn and Adopted Child Coverage. You or your spouse's or domestic partner's newborn or adopted children will be covered for an initial period of 31 days from the date of birth, placement for adoption, or adoption. For an adopted child, the date of adoption is the date you assume or retain a legal obligation to support the child. If you want your newborn or adopted child to continue coverage beyond this time, you must contact your *group* within 31 days of the date of birth, placement for adoption, or adoption to add them to this plan.

Enrollment

Initial Enrollment. Your *group* will have an initial enrollment period for newly eligible and their dependents to enroll for coverage. You may need to meet a waiting period established by the *group* before you can enroll for coverage. See your *group's* human resources or benefits department to determine if there are any waiting periods.

If you or your *dependents* do not enroll during the initial enrollment period you will only be able to enroll during and open enrollment or special enrollment period. Keep reading for more information on open and special enrollment periods.

Open Enrollment. At least once a year your employer will hold an open enrollment period. During the open enrollment period you and your *dependent*s can enroll for coverage. If you do not enroll during the open enrollment period, you may have to wait until the next open enrollment period, unless you qualify for a special enrollment period. See below for more information on special enrollment.

Special Enrollment. Your plan elections chosen during initial or open enrollment are intended to remain the same until the next open enrollment period. However, there may be times when you or your *dependent*s can enroll for coverage outside of the open enrollment period. This is allowed if you have certain qualifying events that happen. Qualifying events are:

- You or your *dependents* did not previously enroll for coverage because you had coverage under another group plan (including COBRA or other continuation coverage) and have since become ineligible for that plan. You must request enrollment within 31 days of this qualifying event.
- You have a change in the number of *dependents* due to marriage, birth, adoption, court order, legal guardianship, or death. You must request enrollment within 31 days of this qualifying event.
- You or your *dependents* lost coverage under Medicaid or a Children's Health Insurance Program (CHIP), or became eligible for a subsidy (state premium assistance program) under Medicaid or CHIP. You must request enrollment within 60 days of this qualifying event.

Notice of Changes in Eligibility. You must tell your *group* if there are any changes that will affect your or your *dependent*'s eligibility. This includes a change in address or a change in the number of your *dependents*. The *group* is then responsible to notify us of any changes according to the terms of the *group contract*. If your *group* fails to notify us of your changes in eligibility, it does not obligate us to pay for your vision care.

Your Effective Date. Your coverage begins at 12:01 a.m. Eastern Time on the *effective date*. Your *effective date* and enrollment requirements are described in the *group contract*. See your employer's human resources or benefits department for more information on your specific *effective date* under this *plan*.

Statements and Forms. *Subscribers* or applicants for membership shall complete and submit applications, questionnaires or other forms or statements the *plan* may reasonably request. Applicants for membership understand that all rights to benefits under this *certificate* are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a *member* may result in termination of coverage as provided in the Termination and Continuation of Coverage section. We will not use a statement made by a *member* to terminate the *member's* contract after two years have passed since the enrollment date. This does not apply, however, to fraudulent misstatements.

Delivery of Documents. We will provide an identification card and a *certificate* for each *subscriber.*

Termination and Continuation Of Coverage

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

If Your Group Cancels Coverage. Your coverage will end if your employer cancels coverage or on the date the *group contract* 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 notify your *group*. See your *group's* human resources or benefits department for more information on how to cancel your coverage. If you cancel, your *group* will be responsible to notify us in writing of the cancellation.

If You or Your Dependents Are No Longer Eligible. Coverage will end when you and/or your *dependents* no longer meet the eligibility requirements as outlined under the section Eligibility and Enrollment. When you or your *dependents* are no longer eligible, the date coverage ends is determined by the *group* in accordance with its eligibility requirements.

Fraud, Intentional Misrepresentation, Misuse of an ID Card. We will cancel this coverage if you or the *group* participates in any kind of intentional misrepresentation of material fact (knowingly provide false information) or fraud during the application and/or enrollment process. Subject to the incontestability provision, we will cancel this coverage if you or the *group* participates in any kind of intentional misrepresentation of material fact (knowingly provide false information) or fraud during the application and/or enrollment process. We may also cancel your coverage for other types of fraud, such as if you allow any other person to use your ID card to obtain benefits, or if you use another *member's* ID card (including one of your *dependent's* ID card) to obtain benefits. You will be held liable for any payments we make as a result of fraud. For any fraud or intentional misrepresentation, coverage will end on the date we send the written notice of cancellation.

If Your Group 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 the grace period as stated in the *group* contract, we may cancel this coverage.

If You Fail to Pay the Premium. If you fail to pay or fail to make satisfactory arrangements with the *group* to pay your portion of the premium, coverage will end as of the last date for which premium was paid.

We Cease to Offer This Coverage. If we cease to offer coverage in the group employer market, we will cancel your coverage in accordance with the terms and conditions of state laws.

Continuation of Coverage
COBRA Continuation of Coverage. 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 Continuation of Coverage Ends. Your continuation of 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 *group contract* 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 (subject to the grace period).
- 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 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.

Continuation of Coverage: Cal-COBRA. Continuation of coverage is available for groups with 2 to 19 employees. See the section Continuation of Coverage: Cal-COBRA for more information.

How Your Benefits Work

This section tells you how we set the payment amount for *covered services*. It will also tell you more about what you pay out-of-pocket for *covered services*, as well as how your choice of *provider* may affect your out-of-pocket costs. The portion you must pay for *covered services* is stated in the Schedule of Benefits at the beginning of this *certificate*.

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

> **Important Note:** We do not 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 *network provider*.

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

> **IMPORTANT:** If you opt to receive optometric services or procedures that are NOT covered services under this plan, a network provider may charge you his or her usual and customary rate for such services or should provide you with a treatment plan that includes each anticipated service or procedure to be given a procedures. Prior to providing you with optometric services or procedures that are not covered services, the provider should provide you with the estimated cost of each service or procedure. To fully understand your coverage, you may wish to review your *certificate*.

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

Please call us or visit our website listed in the Contact Us section for help in finding a *network provider*.

Benefit Maximums, Allowances and Frequency Limits
The amount we pay for your benefits is subject to your benefit maximums, allowances and frequency limits. We will not pay for vision care services that go over your benefit maximums or allowances, or for services that are received more than the allowed frequency limits. Benefit maximums, allowances, and frequency limits are stated in the Schedule of Benefits at the beginning of this *certificate*.

Your Cost Share Requirements
We will pay up to the *maximum allowable amount* for *covered services*. You may be required to pay a part of the *maximum allowable amount*. This is called your cost share amount. *Copayments* are an example of a cost share amount. See the Schedule of Benefits to help determine your cost share amount for *covered services*.

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

We will not pay for vision care that is not covered under this plan. You are required to pay all charges for vision care that is not covered. Vision care received after you have met any benefit maximums or benefit frequency limits are also not covered.

Covered Services

This section describes the *covered services* available under your vision care benefits when received by a *provider*. All *covered services* are subject to the exclusions listed in the Exclusions section and all other conditions and limitations of the *certificate*.

Routine Eye Exam. Your *plan* covers a complete eye exam with dilation as needed. The exam is used to check all aspects of your vision. An eye exam does not include a contact lens fitting fee. Your plan covers a refraction in conjunction with an eye exam. A refraction is your prescription based on your eye exam. *Network providers* should not bill the refraction separately from the routine exam.

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

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

- single vision
- bifocal
- trifocal (FT 25-28)
- standard progressive lenses

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.

Contact Lenses. This *plan* covers elective or non-elective contact lenses. You may receive a benefit for elective contact lenses or non-elective contact lenses, but not both. 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 this *plan*.

> **Note:** Contact lenses are in lieu of your eyeglass lenses benefit. If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in the Schedule of Benefits.

Elective Contact Lenses. Elective contact lenses are contacts that you choose for appearance or comfort.

Non-Elective Contact Lenses. Non-elective contact lenses are prescribed by your provider for diagnoses listed below:

- 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

Important Note: We 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.

Additional Options. Benefits are available for additional services in accordance with the Additional Savings Program. For additional information on available discounts please contact your *network provider* or call customer service.

Exclusions

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

- **Not specifically listed**. Services not listed in the Covered Services section of this *certificate*.
- **Sunglasses**. Sunglass lenses or accompanying frames.
- **Excess amounts**. Any amounts in excess of the maximum benefits stated in this *certificate*.
- **Premium contact lenses fittings**. This includes fittings for more complex applications, including toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable lenses. It also includes extended/overnight wear lenses.
- **Cosmetic Options**. Cosmetic lens options not specifically listed in the Schedule of Benefits or the *covered services* section of this *certificate*. This includes non-prescription eyewear and lenses, plano lenses or lenses that have no refractive power.
- **Eye surgery**. Any diagnostic testing or medical or surgical treatment of the eyes, including any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and/or astigmatism. We also will not cover any contact lenses or eyeglasses required as a result of this surgery.
- **Lost or broken lenses or frames**. Any lost or broken lenses or frames, unless you have reached a new *benefit period*.
- **Experimental or investigative**. Any experimental or investigative services or materials.
- **Uninsured**. Services received before your *effective date* or after your coverage ends.
- **Voluntary payment**. Services for which you are not legally obligated to pay, for which you are not charged, or for which no charge is made in the absence of insurance coverage.
- **Work-related**. Vision services that have been paid under any Worker's Compensation law, federal Medicare program or federal Veteran's Administration program.
- **Government treatment**. Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.
- **Non-licensed vision care providers**. Treatment or services rendered by non-licensed providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed vision care provider under the supervision of a licensed physician or licensed vision care provider, except as specifically provided or arranged by us.
- **Services of relatives**. Professional services or supplies received from a person who lives in your home or who is related to you by blood or marriage.
- **Hospital care**. Inpatient or outpatient hospital vision care.
- **Orthoptics**. Orthoptics or vision training and any associated supplemental testing.
- **Missed or Cancelled Appointments**. We will not pay for appointments a *member* has missed or cancelled.
- **Services or Supplies Combined with Discounts.** We will not pay for services or supplies when combined with any other offer, coupons or in-store advertisement. We will also not pay for certain brands of frames where the manufacturer does not allow discounts.

How to Submit a Claim

This section describes how you submit a claim and what information you should include on your claim. When you receive care from a *network provider*, you do not need to file a claim. The *network provider* will do this for you. However, if you receive vision care from a *non-network provider*, you will need to submit a claim to us.

Notice of Claim. After you receive vision care you will need to contact us, either by phone or mail (see contact information listed below). You should contact us within 20 days of the date you received vision care so we can provide to you claim forms for filing. Notice given by someone on your behalf, or to any agent authorized by us, within information to identify you will be deemed notice to us. If you are unable to contact us within 20 days, it does not mean we will not pay for your claim. Just contact us as soon as reasonably possible.

Claim Forms. We will provide claim forms within 15 days after you notify us. The claim form will have instructions on how to fill it out and where to submit. If you do not receive the claim form within 15 days of your notice, you may send us other written proof of your loss instead, such as an itemized bill from your *provider*. To make it easier to process your claim, the other proof of loss should include 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

Proof of Loss. Your written proof of loss as described above should be provided to us within 90 days after the date of you received vision care. If it is not reasonably possible to provide your written proof of loss within this time, we will not invalidate or reduce your claim. However, you must send it as soon as reasonably possible, and in no event later than a year from when it was due, unless you are legally incapacitated.

Notice of claim, claim forms and other proof of loss can be sent to the following address:

Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111
Phone: (866) 723-0515

Time of Payment of Claims. We will pay claims immediately once we receive written proof of your claim, but not later than 60 days after we receive your proper written proof of loss.

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.

General Provisions

Entire Contract. The law of the state in which the *group contract* was issued will apply unless otherwise stated herein.

Entire Contract – Changes. Your plan is the entire contract of insurance. Your *plan* is made up of this *certificate*, your application (if any), and any amendments. In addition, your employer has the *group contract* and the group master application, which are also a part of your *plan*. No agent of the plan is authorized to change the form or content of this plan or waive any of its provisions. Any changes to the *plan* must be endorsed by an executive officer. All statements made by you or your employer shall be deemed representations and not warranties. No written statement made by you will be used in any context to deny a claim unless a copy of the statement is furnished to you, your beneficiary or personal representative.

Incontestability. The validity of this *plan* will not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue. No statement made by you or your *dependents* relating to you or your *dependent's* insurability will be used to contest the validity of this *certificate* unless the statement is contained in a written instrument signed by your or your *dependents*.

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 any provider.

Right of Recovery. When we 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. We may deduct any overpayment from pending or future claims.

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.

Legal Actions. No action at law or in equity shall be brought to recover on this *plan* prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this *plan*. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

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

Grace Period. Your *group* is responsible to pay premiums on your behalf. After the first premium payment, your *group* has a grace period of 31 days to pay any *premium* due. During the grace period, your coverage will continue in force unless your *group* has given us written notice to cancel the coverage in accordance with the terms of the *group contract*. Your *group* is responsible to pay any premium to the plan. However, you may be required to pay a portion of the premium to your *group*. See your *group* for more information on premiums.

Conformity with the Law. Any provision of this *plan* which is in conflict with the laws of the state in which the *group contract* is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Modifications. We may change this *plan*, including the premiums, at any time by providing notice to the *group* at least 30 days before the change takes effect.

Notice of Privacy Practices. We maintain a privacy program designed to protect your health information consistent with applicable law. In addition to various laws governing your privacy, we have our own privacy policies and procedures in place that are designed to protect your information. We are required by law to provide individuals with notice of our legal duties and privacy practices. To obtain a copy of this notice, call us or visit the website listed in the Contact Us section of this *certificate*.

Reservation of Discretionary Authority
The following provision only applies where the interpretation of this *certificate* is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq. The *plan*, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, has complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation,

determination of whether the services, care, treatment, or supplies are covered. However, a *member* may utilize all applicable grievance and appeals procedures.

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

Binding Arbitration

Important Note: If your coverage is provided pursuant to an employer-sponsored benefit plan that is exempt from ERISA or if you have a dispute that is not governed by ERISA you will be subject to the following binding arbitration provision.

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE POLICY/PLAN OR ANY OTHER ISSUES RELATED TO THE POLICY/PLAN AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT.

It is understood that any dispute including disputes relating to the delivery of services under the plan or any other issues related to the plan, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

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

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

The arbitration is initiated by the Insured making a written demand on Anthem Blue Cross Life and Health Insurance Company. The arbitration will be conducted by a single neutral arbitrator from Judicial Arbitration and Mediation Services ("JAMS"), according to JAMS' applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by a single neutral arbitrator from another neutral arbitration entity, by agreement of the Insured and Anthem Blue Cross Life and Health Insurance Company, or by order of the court, if the Insured and Anthem Blue Cross Life and Health Insurance Company cannot agree. If the parties cannot agree on the individual neutral arbitrator, the arbitrator will be selected in accordance with JAMS Rule 15 (or any successor rule). For those cases or disputes for which the total amount of damages claimed is fifty thousand dollars ($50,000) or less, such single neutral arbitrator shall have no jurisdiction to award more than fifty thousand dollars ($50,000). If the parties are unable to agree on the selection of a single neutral arbitrator for any such case or dispute claiming damages of $50,000 or less, the method provided in Section 1281.6 of the California Code of Civil Procedure shall be utilized.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. Unless you, and Anthem Blue Cross Life and Health Insurance Company agree otherwise, the arbitrator may not consolidate more than one person's claims, and may not otherwise preside over any form of a representative or class proceeding.

Please send all binding arbitration demands in writing to:
Anthem Blue Cross and Blue Shield
P.O. Box 8504
Mason, OH 45040-7111

Continued on next page

Department of Insurance
If you have a problem regarding your coverage, please contact Anthem Blue Cross Life and Health first to resolve the issue. If contacts between you (the complainant) and Anthem Blue Cross Life and Health Insurance Company (the Insurer) have failed to produce a satisfactory solution to the problem, you may wish to contact the Department of Insurance. They can be reached by writing to:

California Department of Insurance
Consumer Services Division
300 South Spring St., South Tower Los Angeles, CA 90013
Toll-free phone number: 1-800-927-HELP (4357)
TDD Number: 1-800-482-4TDD (4833)

Complaints
If you have a complaint about services from Anthem Blue Cross Life and Health or your health care provider, please contact us at:

Anthem Blue Cross Life and Health
PO Box 9304
Mpls, MN 55440-9304
(866) 723-0515

Continuation of Coverage Cal-Cobra

If the group is an employer with 2 to 19 full-time, permanent, active employees on a typical business day, you may be entitled, in accordance with the provisions of this Part, to continue for a limited period of time coverage that would otherwise end. In order to continue coverage, you must meet certain qualifications, and you and the *group* must also satisfy certain requirements, according to the provisions set forth throughout this section.

Definitions

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

Initial Enrollment Period is the period of time following the original Qualifying Event, as indicated in the "Terms of Cal-Cobra Continuation" provisions in this section.

Qualified Beneficiary means: (a) a person enrolled for this Cal-COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *certificate* as either a *subscriber* or *dependent*, (b) a child who is born to or placed for adoption with the *subscriber* during the Cal-COBRA continuation period, or (c) a child for whom the *subscriber* or spouse has been appointed permanent legal guardian by final court decree or order during the Cal-COBRA continuation period. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any *dependents* acquired during the Cal-COBRA continuation period, with the exception of newborns, adoptees, and children of permanent legal guardians as specified above.

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

A. For subscribers and dependents:

1. The *subscriber's* termination of employment, for any reason other than gross misconduct; or
2. A reduction in the *subscriber's* work hours.

B. For dependents:

1. The death of the *subscriber*;
2. The spouse's divorce or legal separation from the *subscriber*;
3. The end of a child's status as a dependent child, as defined by the *plan*;
4. The *subscriber's* entitlement to Medicare; or
5. The loss of eligible status by an enrolled *dependent*.

Eligibility for Cal-Cobra Continuation

A *subscriber* or *dependent* may choose to continue coverage under the *certificate* if his or her coverage would otherwise end due to a Qualifying Event.

Exception: A *member* is not entitled to continue coverage if, at any time of the Qualifying Event:

1. The *member* is entitled to Medicare;
2. The *member* is covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a preexisting condition of the *member*;
3. We fail to receive timely notice of the Qualifying Event or election of a Cal-COBRA continuation (please see TERMS OF CAL-COBRA CONTINUATION);
4. The *member* fails to submit the required premiums;
5. The *member* is covered, becomes covered, or is eligible for federal COBRA; or
6. The *member* is covered, becomes covered, or is eligible for coverage pursuant to Chapter 6A of the Public Health Service Act, 29 U.S.C. Section 1161 et seq. If one *member* is unable to continue coverage for these reasons, other entitled *members* may still choose to continue their coverage.

Terms of Cal-Cobra Continuation

1. For Qualifying Event A. above, the group must notify the *subscriber* and us within 30 days of the Qualifying Event of the right to continue coverage. We in turn must within 14 days give you official notice of the Cal-COBRA continuation right.
2. You must inform us within 60 days of Qualifying Event B. above if you wish to continue coverage. We in turn must within 14 days give you official notice of the Cal-COBRA continuation right.

If you choose to continue coverage, you must notify us within 60 days of the later of: (i) the date your coverage under the *plan* terminates by reason of a Qualifying Event, or (ii) the date you were sent notice of your Cal-COBRA continuation right. The Cal-COBRA continuation coverage may be chosen for all *members* within a covered family, or only for selected *members*.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in higher cost or you could be denied coverage entirely.

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

The initial premiums must be delivered to us within 45 days after you elect Cal-COBRA continuation coverage.

An election of continuation coverage must be in writing and delivered to us by first class mail or other reliable means of delivery, including personal delivery, express mail or private courier company. The initial premiums must be delivered to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9062, Oxnard, CA 93031-9062 by first class mail, certified mail or other reliable means of delivery, including personal delivery, express mail or private courier company, and must be in an amount sufficient to pay all premiums due. **A failure to properly give notice of an election of continuation coverage or a failure to properly and timely pay premiums due will disqualify you from continuing coverage under this Part.**

If you have Cal-COBRA continuation coverage under a prior plan that terminates because the policy between the employer and the prior plan terminates, you may elect continuation coverage under the *plan*, which will continue for the balance of the period under which you would have remained covered under the prior plan. To do so, you must make the election and pay all premiums on the terms described above and below. Such continuation coverage will terminate if you fail to comply with the requirements for enrolling in and paying premiums to us within 30 days of receiving notice of the termination of the prior plan.

Additional dependents. A child acquired during the Cal-COBRA continuation period is eligible to be enrolled as a *dependent* and has separate rights as a Qualified Beneficiary. The standard enrollment provisions of the *certificate* apply to enrollees during the Cal-COBRA continuation period. A *dependent* acquired and enrolled after the effective date of continuation coverage resulting from the original Qualifying Event is not eligible for a separate continuation if a subsequent Qualifying Event results in the person's loss of coverage.

Cost of Coverage. You must pay us the premium required under the *plan* for your Cal-COBRA continuation coverage, and the notice of your Cal-COBRA continuation right, which you will receive from us, will include the amount of the required premium payment. This cost, called the "premium," must be remitted to us by the first of each month during the Cal-COBRA continuation period and shall be 110% of the rate applicable to a *member* for whom a Qualifying Event has not occurred. The first payment of the premium is due within 45 days after you elect Cal-COBRA. **We must receive subsequent payments of the premium from you by the first of each month in order to maintain the coverage in force.**

Besides applying to the *subscriber*, the *subscriber's* rate also applies to:

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

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

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

termination of employment).

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

For *dependents* properly enrolled during the Cal-COBRA continuation, coverage begins according to the enrollment provisions of the *plan*.

When Cal-COBRA Continuation Ends.
For members beginning Cal-COBRA continuation coverage effective on or after January 1, 2003, this continuation will end on the earliest of:

1. The end of thirty-six (36) months from the Qualifying Event;*
2. The date the *certificate* terminates;
3. The end of the period for which premiums are last paid;
4. The date the *member* becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a preexisting condition of the *member*, in which case this Cal-COBRA continuation will end at the end of the period for which the preexisting condition exclusion or limitation applied;
5. In the case of (a) a *subscriber* who is eligible for continuation coverage because of the termination of employment or reduction in hours of the *subscriber's* employment (except for gross misconduct) and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first sixty (60) days of continuation coverage and (b) his or her spouse or dependent child who has elected Cal-COBRA coverage, the end of thirty-six (36) months from the Qualifying Event. If the *subscriber* is no longer disabled under Title II or Title XVI, benefits shall terminate on the later of thirty-six (36) months from the Qualifying Event or the month that begins more than thirty-one (31) days after the date of the final determination under Title II or Title XVI that the *subscriber* is no longer disabled;
6. The date the *member* becomes entitled to Medicare;
7. The date the employer, or any successor employer or purchaser of the employer, ceases to provide any group benefit plan to his or her employees; or
8. The date the *member* moves out of the *plan*'s service area or commits fraud or deception in the use of services.

*For a *member* whose Cal-COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan.

If your Cal-COBRA continuation under this *plan* ends in accordance with items 1. or 2. above, you are eligible for medical conversion coverage. We must provide notice of this conversion right within 180 days prior to such termination date.

If your Cal-COBRA continuation coverage under this *plan* ends because the *group* replaces our coverage with coverage from another company, the *group* must notify you at least thirty (30) days in advance and let you know what you have to do to enroll for coverage under the new plan for the balance of your Cal-COBRA continuation period.

For members beginning Cal-COBRA continuation coverage effective prior to January 1, 2003, this continuation will end on the earliest of:

1. The end of eighteen (18) months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
   Note: The eighteen (18) months may be extended for up to twenty-nine (29) months for total disability as determined by the Social Security Administration.
2. The end of thirty-six (36) months from the Qualifying Event, if the Qualifying Event was the death of the *subscriber*, divorce or legal separation, or the end of *dependent* status;*
3. For a *dependent*, the end of thirty-six (36) months from the date the *subscriber* became entitled to Medicare, if the Qualifying Event was the *subscriber's* entitlement to Medicare;
4. The date the *certificate* terminates;
5. The end of the period for which premiums are last paid;
6. The date the *member* becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a preexisting condition of the *member*, in which case this Cal-COBRA continuation will end at the end of the period for which the preexisting condition exclusion or limitation applied;
7. In the case of (a) a *subscriber* who is eligible for continuation coverage because of the termination of employment or reduction in hours of the *subscriber's* employment (except for gross misconduct) and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first sixty (60) days of continuation coverage, and (b) his or her spouse or dependent child who has elected Cal-COBRA coverage, the end of eighteen (18) months from the Qualifying Event. If the *subscriber* is no longer disabled under Title II or Title XVI, benefits shall terminate on

the later of eighteen (18) months from the Qualifying Event or the month that begins more than thirty-one (31) days after the date of the final determination under Title II or Title XVI that the *subscriber* is no longer disabled;
8. The date the *member* becomes entitled to Medicare;
9. The date the employer, or any successor employer or purchaser of the employer, ceases to provide any group benefit plan to his or her employees; or
10. The date the *member* moves out of the *plan*'s service area or commits fraud or deception in the use of services.

*For a *member* whose Cal-COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan.

If your Cal-COBRA continuation under this *plan* ends in accordance with items 1., 2., 3. or 4. above, you are eligible for medical conversion coverage. We must provide notice of this conversion right within 180 days prior to such termination date.

If your Cal-COBRA continuation coverage under this *plan* ends because the *group* replaces our coverage with coverage from another company, the *group* must notify you at least thirty (30) days in advance and let you know what you have to do to enroll for coverage under the new plan for the balance of your Cal-COBRA continuation period.

Extension of Continuation During Total Disability

Important Note: This section (Extension of Continuation During Total Disability) applies only to *members* who began Cal-COBRA continuation coverage effective prior to January 1, 2003.

If, at the time of termination of employment or reduction in hours or at any time during the first 60 days of a Cal-COBRA continuation, a Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered *members* may be entitled to up to 29 months of continuation coverage after the original Qualifying Event. The *member* must furnish us with written notice within 30 days of the Social Security Administration's decision that the *member* is no longer totally disabled.

Eligibility for Extension. To continue coverage for up to 29 months from the date of the original Qualifying Event, the disabled *member* must:
1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and
2. Be determined and certified to be so disabled by the Social Security Administration.

Notice. The *member* must furnish us with proof of the Social Security Administration's determination of disability during the first 18 months of the Cal-COBRA continuation period and no later than 60 days after the date of the Social Security Administration's determination of such disability.

Cost of Coverage. For the 19th through the 29th months that the total disability continues, you must remit to us the cost for extended continuation coverage. This cost (called the "premium") shall be subject to the following conditions:
1. This charge shall be 150% of the applicable rate, depending upon the number of persons covered, and must be remitted to us by you by the first of each month during the period of extended continuation coverage.
2. We must receive the premium from you by the first of each month in order to maintain the extended continuation coverage in force.

When the Extension Ends. This extension will end at the earliest of:
1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;
2. The end of a period of 29 months from the Qualifying Event;
3. The date the *certificate* terminates;
3. The end of the period for which premiums are last paid;
4. The date the *member* becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a preexisting condition of the *member*, in which case this Cal-COBRA extension will end at the end of the period for which the preexisting condition exclusion or limitation applied;
5. In the case of (a) a *subscriber* who is eligible for continuation coverage because of the termination of employment or reduction in hours of the *subscriber's* employment (except for gross misconduct) and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first 60 days of continuation coverage and (b) his or her spouse or dependent child who has elected Cal-COBRA coverage, the end of 36 months from the Qualifying Event. If the *subscriber* is no longer disabled under Title II or Title XVI, benefits shall terminate on the later of 36 months from the Qualifying Event or the month that begins more than 31 days after the date of the final determination under Title II or Title XVI that the *subscriber* is no longer disabled;

7. The date the *member* becomes entitled to Medicare;
8. The date the employer, or any successor employer or purchaser of the employer, ceases to provide any group benefit plan to his or her employees; or
9. The date the *member* moves out of the *plan*'s service area or commits fraud or deception in the use of services.

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

Post Cal-Cobra Continuation of Coverage for Qualifying Events Occurring For Ages 60 And Over

Important Note: This section (Post Cal-Cobra Continuation of Coverage for Qualifying Events Occurring for Ages 60 and Over) applies only when *subscribers* turn sixty (60) years of age prior to January 1, 2005.

Subject to payment of premiums stated in the *plan*, coverage under the *plan* may be continued for the *subscriber*, the *subscriber's* spouse and the *subscriber's* former spouse (if any) under Section 10116.5 of the Insurance Code, in accordance with the following provisions. This continuation may be elected following the "Cal-Cobra Continuation of Coverage" shown above.

For the purposes of this section, "former spouse" means: (a) an individual who is divorced from the *subscriber*; or (b) an individual who was married to the *subscriber* at the time of the *subscriber's* death.

The *subscriber*, spouse and former spouse may continue coverage under the *plan* if:
1. The *subscriber*, or the *subscriber* on behalf of himself or herself and the spouse, was entitled to, and had elected to continue coverage under, Cal-COBRA as described in the preceding section;
2. The *subscriber* or spouse has not elected to continue coverage under any other available continuation;
3. The *subscriber* has worked for the employer for at least five years prior to termination of employment; and
4. The *subscriber* is at least 60 years old on the date employment with the *group* ended.

The former spouse may continue coverage under this *plan* in accordance with this section if he or she was covered as a Qualified Beneficiary under Cal-COBRA.

TERMS OF CAL-COBRA EXTENSION OF CONTINUATION OF COVERAGE

Important Note: This section (Terms of Cal-Cobra Extension of Continuation of Coverage) applies ONLY when *subscribers* turn sixty (60) years of age prior to January 1, 2005.

Notice and Election. We will notify you and your spouse or former spouse of the right to an extension in your continuation of coverage at least 90 days prior to the date continuation of coverage under Cal-COBRA is scheduled to end.

If you choose to continue coverage, you must notify us in writing within 30 days prior to the end of your Cal-COBRA continuation period. If you fail to elect the extended Cal-COBRA continuation during the Post Cal-COBRA election period, you may not elect the Cal-COBRA continuation at a later date.

Cost of Coverage. You must pay us the premium required under the *plan* for your Cal-COBRA extended coverage, and the notice of your Cal-COBRA extended coverage right, which you will receive from us, will include the amount of the required premium payment. This cost, called the "premium," must be remitted to us by the first of each month during the Cal-COBRA extended continuation period and shall be 110% of the rate applicable to an *member* for whom a Qualifying Event has not occurred. **We must receive payment of the premium from you by the first of each month in order to maintain the coverage in force.**

Besides applying to the *subscriber*, the *subscriber's* rate also applies to a spouse or former spouse whose Cal-COBRA continuation began due to divorce, separation or death of the *subscriber*.

When Post Cal-COBRA Continuation Ends. This continuation will end on the earliest of:
1. The date the *certificate* terminates;
2. The end of the period for which premiums are last paid;
3. The date the *member* becomes covered under any other group health coverage;
4. The date the *member* becomes eligible for Medicare;
5. For a spouse or former spouse of the *subscriber*, five years from the date on which continuation coverage under Cal-COBRA was scheduled to end for the *subscriber*;
6. In the case of (a) a *subscriber* who is eligible for continuation coverage because of the termination of employment or

reduction in hours of the *subscriber's* employment (except for gross misconduct) and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first 60 days of continuation coverage and (b) his or her spouse or dependent child who has elected Cal-COBRA coverage, the end of 36 months from the Qualifying Event. If the *subscriber* is no longer disabled under Title II or Title XVI, benefits shall terminate on the later of 36 months from the Qualifying Event or the month that begins more than 31 days after the date of the final determination under Title II or Title XVI that the *subscriber* is no longer disabled;

7. The date on which the employer or former employer terminates its group insurance policy with the health care services plan and no longer provides coverage for any active employees through the plan;
8. The date the *member* reaches age 65;
9. The date the employer, or any successor employer or purchaser of the employer, ceases to provide any group benefit plan to his or her employees; or
10. The date the *member* moves out of the *plan*'s service area or commits fraud or deception in the use of services.

If your Cal-COBRA continuation under this *plan* ends in accordance with items 1. or 5. above, you may be eligible for medical conversion coverage. We must provide notice of this conversion right within 180 days prior to such termination date.

If your Cal-COBRA continuation coverage under this *plan* ends because the *group* replaces our coverage with coverage from another company, the *group* must notify you at least 30 days in advance and let you know what you have to do to enroll for coverage under the new plan for the balance of your Cal-COBRA continuation period.

Statement of ERISA Rights

As a member of this plan, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA generally does not apply to church plans or to governmental plans, such as plans sponsored by city, county, or statement governments, or public school systems. Check with your *group* to determine if your plan is subject to ERISA.

As part of your rights, you may examine, without charge, at your *group's* plan administrator's office or at other specified locations, all plan documents. These include insurance contracts, copies of all documents filed by the plan with the Department of Labor (such as detailed annual reports) and plan descriptions. You may obtain copies of all plan documents and other plan information by writing to your *group's* plan administrator. The administrator may make a reasonable charge for the copies.

Plan Fiduciaries. In addition to creating rights for plan members, ERISA imposes duties upon the people who are responsible for the operation of your employee benefit plan. The people who operate your plan are called "fiduciaries" of the plan. They have a duty to operate the plan prudently and in the interest of you and other plan members.

- No one may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
- If your claim for a welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial.
- You have the right to have the plan administrator review and reconsider your claim.

Enforcement of ERISA Rights. Under ERISA, there are steps to enforce the rights listed above. For instance:

- If you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials (unless the materials were not sent because of reasons beyond the control of the administrator).
- If you have a claim for benefits for an appeal of a coverage decision, which is denied or ignored, in whole or in part, you may file suit in a state of federal court.
- If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court decides who pays court costs and legal fees.

If you are successful, the court may order the person you have sued to pay the court costs and fees. If you lose, the court may order you to pay these costs and fees. You may lose if, for example, the court finds your claim to be frivolous.

Assistance. If you have questions about your plan, contract your *group*. If you have questions about this statement about your rights under ERISA, contact the nearest Area Office of the Employee Benefits Security Administration, Department of Labor. You can find the contact information in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

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 italicized. The word or phrase is defined in this section or at the place in the text where it is used.

Allowance. A dollar amount available to apply towards materials or services.

Certificate. This summary of the terms of your benefits. It is attached to and is a part of the *group contract* and is subject to the terms of the *group contract*.

Copayment (or copay). A specific dollar amount indicated in the Schedule of Benefits for which you are responsible.

Covered Services. Services and supplies or treatment as described in the *certificate* which are performed, prescribed, directed or authorized by a *provider*. A *covered service* is incurred on the date the service, supply or treatment was provided to you. 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 this *certificate* is in force;
- Within the *maximum allowable amount*;
- Not specifically excluded or limited by the *certificate*;
- Specifically included as a benefit within the *certificate*.

Dependent. A member of the *subscriber's* family who is eligible for coverage under the *plan* as described in the Eligibility and Enrollment section of this *certificate***.**

Effective Date. The date when your coverage begins under this *certificate*.

Group. The employer that has entered into a *group contract* with us to provide the benefits of the *plan***.**

Group Contract. The contract issued by us to the *group* as a means of providing certain benefits to the *group's* employees and eligible *dependents*.

Last Date of Service. The period of time in which benefits are tracked. You must wait until the specific interval from the last date of service to receive *covered services* again under the *plan*. See the Schedule of Benefits for more information.

Maximum Allowable Amount. The maximum amount allowed for *covered services* you receive based on the fee schedule. The maximum allowable amount is subject to any copayments, coinsurance, limitations or exclusions listed in this *certificate*.

For a *network provider*, the maximum allowable amount is equal to the amount that constitutes payment in full under the *network provider's* participation agreement for this product. If a *network provider* accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the maximum allowable amount.

For a *non-network provider* who is a physician or other non-facility *provider*, even if the *provider* has a participation agreement with us for another product, the maximum allowable amount is the lesser of the actual charge or the standard rate under the participation agreement used with *network providers* for this plan.

The maximum allowable amount is reduced by any penalties for which a *provider* is responsible as a result of its agreement with us.

Member. A *subscriber* or *dependent* who has satisfied the eligibility conditions; applied for coverage; been accepted by us for coverage; and for whom premium payment has been made. *Members* are sometimes called "you" and "your."

Network Provider. A *provider* who has entered into a contractual agreement or is otherwise engaged by us to provide *covered services* and certain administration functions for the network associated with this *plan*.

Non-Network Provider. A *provider* who has not entered into a contractual agreement with us for the network associated with this *plan*.

Plan. The entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this *certificate*, your application (if any), any endorsements, the *group contract,* and the group master application.

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

Subscriber. The employee or other member of the group that has enrolled and been accepted for coverage under this *plan*.

Get Help in Your Language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda**. (TTY/TDD: 711)**

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة
)TTY/TDD.(711 :

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید.(TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ्त में प्राप्त करने का अधिकार है। मदद के धिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉि करें । (TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិកុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដលែមានលេីប័ណ្ណ ID របស់អ្នកដេីម្បីទទួលជំនួយ។(TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਚਿ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਚਿ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਕਿਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਬਰ ਸਰਵਸਿਜਿ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.