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Underwritten by Anthem Insurance Companies, Inc.

Your Health Certificate

Certificate of Coverage

(herein called the "Certificate")

Blue Retiree Plan

Anthem Insurance Companies, Inc.

120 Monument Circle

Indianapolis, Indiana 46204

1 CERTIFICATE

Welcome to Anthem! This Certificate has been prepared by Us to help explain your coverage. Please refer to this Certificate whenever you require medical services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Certificate is not a Medicare Supplement Certificate. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Plan.

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

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

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

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

How to Obtain Language Assistance

We are committed to communicating with Our Members about their health plan, regardless of their language. We employ a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Customer Service.



President

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2 MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, you have the right to:

- Receive information about the organization and its services, practitioners and Providers, and Members' rights and responsibilities;
- Be treated respectfully, with consideration and dignity;
- Receive all the benefits to which you are entitled under your Certificate and Schedule of Benefits;
- Obtain from your Provider complete information regarding your diagnosis, treatment and prognosis in terms you can reasonably understand;
- Receive quality health care through your Provider in a timely manner and in a medically appropriate setting;
- Have a candid discussion with your Provider about treatment options, regardless of their cost or whether they are covered under your Certificate;
- Participate with your Provider in decision making about your healthcare treatment;
- Refuse treatment and be informed by your Provider of the medical consequences;
- Receive wellness information to help you maintain a healthy lifestyle;
- Express concern and complaints about the care and services you received from a Provider, or the service you received from Us, and to have Us investigate and take appropriate action;
- File a complaint with Us, to Appeal that decision as outlined in the **Member Grievance** section of this Certificate, and to Appeal a decision to the Department of Insurance without fear of reprisal;
- Privacy and confidential handling of your information;
- Make recommendations regarding Our rights and responsibilities policies; and
- Designate or authorize another party to act on your behalf, regardless of whether you are physically or mentally incapable of providing consent.

As a Member, you have the responsibility to:

- use Providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-Physician relationship with that Physician;
- provide complete and honest information about your health care status;
- follow the treatment plan recommended by your Provider responsible for your care;
- understand how to access care in routine, emergency and urgent situations, and to know your health care benefits as they relate to out-of-area coverage, Copayments, etc.;
- notify your Provider or Us about concerns you have regarding the services or medical care you receive;
- be considerate of the rights of other Members, Providers and Our staff;

- read and understand your Certificate and Schedule of Benefits; and
- provide accurate and complete information to Us about other health care coverage and/or insurance benefits you may carry.

We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Certificate and not by this Member Rights and Responsibilities statement.

3 SCHEDULE OF BENEFITS

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

Under certain circumstances, if We pay the Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, We may collect such amounts directly from you. You agree that We have the right to collect such amounts from you.

Pre-Existing Period

Late Enrollee

18 Months after your Enrollment Date

SECTION 1 Medicare Complementary Benefits

<u>Covered Services</u>	<u>Medicare Part A Pays</u>	<u>Your Copayments, Maximums, Responsibilities</u>
Hospital Care		
First 60 Days of Medicare Benefit Period	Medicare Eligible Expense for Medicare Medically Necessary Hospital care in a semi-private room - EXCEPT for the Medicare Part A Deductible	The Medicare Part A Deductible Covered In Full
61st through 90th day of Medicare Benefit Period	Medicare Eligible Expenses for Medicare Medically Necessary Hospital care in a semi-private room - EXCEPT for the Medicare Part A Coinsurance	The Medicare Part A Coinsurance Covered In Full
91st through 150th day of Medicare Benefit Period	Medicare Eligible Expenses for a Maximum Amount of 60 Lifetime Reserve Days during your lifetime for Medicare Medically Necessary Hospital care in a semi-private room - EXCEPT for the Medicare Part A Coinsurance	The Medicare Part A Coinsurance, upon exhaustion of Lifetime Reserve Days, 10% of Medicare Eligible Expenses, up to an additional 365 days during your lifetime
After 150th day	Nothing	Upon exhaustion of Lifetime Reserve Days, 10% of Medicare Eligible Expenses, up to an additional 365 days during your lifetime

Skilled Nursing Facility Care

First 20 Days	Medicare Eligible Expense Covered In Full for first 20 days in a semi-private room	
21st Day through 100th Day	Medicare Eligible Expense - EXCEPT for the Medicare Part A Coinsurance	The Medicare Part A Coinsurance Covered In Full
After 100th Day	Nothing	See Section 2 Major Medical benefits for additional coverage

Home Health Care

Medicare Eligible Expense - EXCEPT for the Medicare Part A Coinsurance

The Medicare Part A Coinsurance Covered In Full

Blood

Medicare Eligible Expense - EXCEPT for the first 3 pints of blood

The first 3 pints of blood Covered In Full

Hospice Care

Medicare Eligible Expenses for Medicare Medically Necessary Hospice care - EXCEPT for the Medicare Part A Coinsurance

The Medicare Part A Coinsurance Covered In Full

<u>Covered Services</u>	<u>Medicare Part B Pays</u>	<u>Your Copayments, Maximums, Responsibilities</u>
Physician and Other Out-patient Care	Medicare Eligible Expenses for Medicare Medically Necessary Physician's services and other Outpatient services - EXCEPT for the Medicare Part B Deductible and the Medicare Part B Coinsurance.	The Medicare Part B Deductible and the Medicare Part B Coinsurance Covered In Full.
Outpatient Hospital Care	Medicare Eligible Expenses for Medicare Medically Necessary Outpatient Hospital care eligible under Medicare Part B - EXCEPT for the Medicare Part B Deductible and the Medicare Part B Coinsurance.	The Medicare Part B Deductible and the Medicare Part B Coinsurance Covered In Full.
Medicare Part B Excess Charges on Non-Assigned Claims	Nothing	Covered in Full of the difference between the Medicare Part B billed charge and the Medicare Part B approved charge if the Provider has not accepted Medicare assignment.
Blood	Medicare Eligible Expenses - Except for the first 3 pints of blood and the Medicare Part B Coinsurance.	The first 3 pints of blood and the Medicare Part B Coinsurance Covered In Full.
Outpatient (Non-Hospital) Treatment of Mental Health Conditions	Medicare Eligible Expenses - Except for the Medicare Part B Deductible and the Medicare Part B Coinsurance	The Medicare Part B Deductible and the Medicare Part B Coinsurance Covered In Full.
Outpatient (Non-Hospital) Physical Therapy Including Speech and Occupational Therapy	Medicare Eligible Expenses for certain therapy services - EXCEPT for the Medicare Part B Deductible and the Medicare Part B Coinsurance.	The Medicare Part B Deductible and the Medicare Part B Coinsurance Covered In Full.

SECTION 2 Major Medical Benefits

In addition to the above benefits, Section 2 Major Medical pays for services to the extent they are not paid or payable by Medicare Parts A or B whether or not you have enrolled in Medicare Part B, or under Section 1 Medicare Complementary Benefits. NOTE: Anthem

will use its own standards for determining Medical Necessity and Experimental/Investigative services, not Medicare's, for Covered Services eligible under Section 2 Major Medical Benefits. The Schedule of Benefits is a summary of the Deductibles, Copayments and other limits when you receive Covered Services from a Provider. Please refer to the Covered Services section for a more complete explanation of the specific services covered by the Plan. This Schedule of Benefits lists the Member's responsibility for Covered Services and supplies. Benefits for Covered Services are based on the Maximum Allowable Amount. You are responsible for any balance due between the Provider's charge and the Maximum Allowable Amount in addition to any Copayments, Deductibles, and non-covered charges.

In addition to the services listed below, Covered Services include other Medicare eligible and ineligible services that Anthem determines to be Medically Necessary and not Experimental or Investigational in nature.

Anthem Benefit Period Calendar Year

Deductible

Per Person \$100

Note: When a Member incurs covered medical expenses during the last 3 months of a Benefit Period, which are applied against but do not satisfy that year's Deductible, those expenses may be carried over and applied against the Deductible(s) for the next Benefit Period, but not the Out of Pocket. If the Deductible is met, there is no carry-over credit given.

Out-of-Pocket Limit

Per Person \$600

Note: The Out-of-Pocket Limit includes all Major Medical Deductibles and/or percentage Copayments you incur in an Anthem Benefit Period.

Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional Copayments will be required for the Member and/or family for the remainder of the Anthem Benefit Period.

Lifetime Maximum for All Other Covered Services \$1,000,000

Covered Services For Major Medical Benefits

Copayments/Maximums

Inpatient Services (after 60 lifetime reserve days and additional 365 days have been exhausted under Section 1) Semi-private room: 20%
 Private Room (average semi-private room rate - if Medically Necessary or if the Hospital has private rooms only.

Ancillary	20%
Skilled Nursing Facility (SNF) after the 100th day Semi-private room; Private room (average semi-private SNF room rate)	20% of the Medicare Eligible Expenses
Outpatient Substance Abuse	20%
Services Received Outside of U.S.A.	Covered In Full of the Maximum Allowable Amount for expenses each calendar year
Home Health Care	20%
Maximum amount payable	\$5,000 per calendar year
Home IV Therapy Drugs/Injectable Drugs	20%
Private Duty Nursing/Visting Nurse's Association	20%
Maximum amount payable	\$5,000 maximum per calendar year
Accidental Dental	20%
Routine physical exams	Covered In Full
Maximum amount payable	\$150 per Member per calendar year
Hearing tests	Covered In Full
Maximum amount payable	\$50
Dental Services	Covered In Full
Maximum amount payable	\$50 per Member, per calendar year

State Mandated Benefits

These benefits are required to be covered by group health plans in Indiana; they will usually be paid by Medicare and Section 1 Medicare Complementary Benefits.

Mastectomy Reconstruction	Same As Any Other Condition
Diabetes Management	Same As Any Other Condition
Mammography Screening Services	Covered In Full
Prostate Screening	20%, subject to the Deductible; limit one routine prostate screening examination per Member per calendar year
Colorectal Cancer Testing	Covered in Full not subject to the Deductible; limit one routine colorectal cancer examination and related laboratory tests for cancer per Member per calendar year.
Morbid Obesity Treatment Services	20%, subject to the Deductible

*See Covered Services section for any exceptions, limitations, additional detailed descriptions, etc.

4 DEFINITIONS

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

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

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

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

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

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

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

Custodial Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. **Anthem will determine whether services are Custodial Care and are not Medically Necessary under Section 2 Major Medical benefits.** Custodial care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and

- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

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

Dependent - Your eligible Dependent, as described in the **Eligibility and Enrollment** section.

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

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

Effective Date - The date when your coverage begins under this Certificate.

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

Enrollment Date - The first day of coverage or, if there is a waiting period, the first day of the waiting period.

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

Experimental/Investigative - Anthem

will determine whether services eligible for payment under Section 2 Major Medical benefits are Experimental/Investigative. Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine in Our sole discretion to be Experimental/Investigative. We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria

above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

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

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under Section 2 Major Medical benefits.

External Grievance - Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Certificate.

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

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

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

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

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

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

Late Enrollee - An eligible person who applies to enroll other than within thirty one (31) days of (i) the earliest date on which coverage can become effective under this Certificate; or (ii) an event which qualified for Special Enrollment, as that term is defined in this Certificate.

Late Enrollment - Enrollment other than on:

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

Lifetime Maximum - The maximum dollar amount We will pay for Covered Services during your lifetime. This is applicable to all Major Medical Covered Services.

Maximum Allowable Amount - The amount that We, or Our Subcontractor, determine is the maximum amount payable for Covered Services you receive, up to but not to exceed charges actually billed. Generally, to determine the Maximum Allowable Amount for a Covered Service, We or Our Subcontractor use internally developed criteria and industry accepted methodologies and fee schedules which are based on estimates of resources and costs required to provide a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.

For a Provider who has a participation agreement with Us, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under any participation agreement with Us. If a Provider accepts as full payment an amount less than the negotiated rate under a participation agreement, the lesser amount will be the Maximum Allowable Amount.

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

Medically Necessary or Medical Necessity - Anthem will determine whether services eligible for payment under Section 2 Major Medical benefits are Medically Necessary. An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by Us to be:

1. Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
2. Obtained from a Provider;
3. Provided in accordance with applicable medical and/or professional standards;
4. Known to be effective, as proven by scientific evidence, in materially improving health outcomes;

5. The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
6. Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost);
7. Not Experimental/Investigative;
8. Not primarily for the convenience of the Member, the Member's family or the Provider.
9. Not otherwise subject to an exclusion under this Certificate.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary. Anthem will determine whether services eligible for payment under Section 2 Major Medical benefits are Medically Necessary.

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

Medicare Benefit Period - The period of time used by Medicare to measure your coverage under Medicare Part A. Your first Benefit Period begins on the day you enter a Hospital as a Medicare patient. It ends 60 days after you leave the Hospital (counting the day of your discharge) or, if you have to go from the Hospital to a Skilled Nursing Facility, it ends 60 days after you leave the Skilled Nursing Facility. If you are hospitalized again within 60 days, the second Hospital stay is considered part of the first Benefit Period.

Medicare Coinsurance - That portion of the health care charges that you are required to pay for under Medicare after the applicable Medicare Deductible is met.

Medicare Eligible Expenses - Expenses of the kinds covered by Medicare, to the extent

recognized as reasonable and Medically Necessary by Medicare.

Medicare Medically Necessary - Services and supplies that Medicare determines are necessary for the treatment of illness or injury. **Anthem will determine whether services eligible for payment under Section 2 Major Medical benefits are Medically Necessary.**

Medicare Part A or Part B Deductible - The amount of health care charges Medicare requires you to pay before Medicare Part A or Part B benefits are paid.

Medicare Part B Excess Charges - The difference between the actual Medicare Part B billed charge and the Medicare approved Part B charge for non-assigned claims. The billed charges must not exceed any limitation established by Medicare or state law.

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

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

New FDA Approved Drug Product or Technology does not include:

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

ingredient as their counterpart brand-named medications).

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

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

Pharmacy and Therapeutics Committee - A committee of Physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

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

Pre-Existing Condition - A condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 3 Months period ending on your Enrollment Date. Pregnancy is not considered a Pre-Existing Condition. Genetic information may not be used as a condition in the absence of a diagnosis.

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

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

Provider - A duly licensed person or facility

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

- Ambulatory Surgical Facility - A Provider that:
 1. is licensed as such, where required;
 2. is equipped mainly to do Surgery;
 3. has the services of a Physician and a Registered Nurse (R.N.) at all times when a patient is present;
 4. is not an office maintained by a Physician for the general practice of medicine or dentistry; and
 5. is equipped and ready to initiate emergency procedures with personnel who are certified in Advanced Cardiac Lifesaving Skills.
- Certified Registered Nurse Anesthetist - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a Certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a precertification process administered by the Council on Recertification of Nurse Anesthetists.
- Home Health Care Agency - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services.
- Hospice - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be

available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

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

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

1. nursing care;
 2. rest care;
 3. convalescent care;
 4. care of the aged;
 5. Custodial Care;
 6. educational care;
 7. treatment of alcohol abuse; or
 8. treatment of drug abuse.
- Physician -
 1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or
 2. any other legally licensed practitioner of the healing arts rendering services which are:
 - a. covered by the Plan;
 - b. required by law to be covered when rendered by such practitioner; and
 - c. within the scope of his or her license.

Physician does not include:

1. the Member; or
 2. the Member's spouse, parent, child, sister, brother, or in-law.
- Skilled Nursing Facility - A Provider constituted, licensed, and operated as set forth in applicable state law, which:
 1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
 2. provides care supervised by a Physician;
 3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
 4. is not a place primarily for care of the aged, Custodial Care or Domiciliary Care, or treatment of alcohol or drug dependency; and
 5. is not a rest, educational, or Custodial Provider or similar place.
 - Urgent Care Center - A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery - A Recovery is money you receive from another, their insurer or from any

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

Single Coverage - Coverage for the Subscriber only.

Skilled Care - Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan. **Anthem will determine whether services are Skilled Care and are Medically Necessary under Section 2 Major Medical benefits.**

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

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

5 ELIGIBILITY AND ENROLLMENT

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

In order for you to participate in the Group's benefit plan, certain requirements must be satisfied. These requirements may include probationary or waiting periods. The specific time periods and other standards for participation in the Group's benefit plan are determined by the

Group, or state and/or federal law, and approved by Us. Eligibility requirements are described in general terms below.

For more specific eligibility information you should see your Human Resources or benefits department or the Group.

Eligibility

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

Subscriber

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

1. be retired or be the spouse of a retiree from the Group;
2. be age 65 or older;
3. be enrolled under Parts A and B of Medicare;
4. have not enrolled in a Medicare + Choice Plan, and do not have any Medicare Supplement coverage.

Dependents

To be eligible for Coverage to enroll as a Dependent, you must:

1. be listed on the enrollment form completed by the Subscriber,
2. meet all Dependent eligibility criteria established by the Group, and
3. be enrolled under Parts A and B of Medicare.

The Subscriber's Domestic Partner or Domestic Partnership means a person of the same sex who has signed the Domestic Partner Affidavit certifying that: he or she is the Subscriber's or the Eligible Person's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor Eligible Person is related by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber or Eligible Person.

For purposes of this Certificate, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's unmarried child, adopted

child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law which applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, COB.

A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

To apply for coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. Anthem reserves the right to make the ultimate decision in determining eligibility of the Domestic Partner.

Enrollment

The Subscriber shall furnish to Anthem such notification and other information as may be required by Anthem for the purpose of enrolling Members, processing terminations, effecting changes in single or family contract status, determining the amount payable by the Member under this Contract, or for any other purpose reasonably related to the administration of this Certificate.

Anthem reserves the right to limit retroactive changes to enrollment to a maximum of sixty (60) days from the date notice is received. Acceptance of payments from the Member or the payment of benefits to persons no longer eligible will not obligate Anthem to provide benefits.

Initial Enrollment

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

Newly Eligible Persons

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

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

Special Enrollment/Special Enrollees

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

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

Portability

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

Continuous Coverage

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

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

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

including the Lifetime Maximum.

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

THIS SECTION DOES NOT APPLY TO YOU IF YOU:

- Change from an individual Anthem Blue Cross Blue Shield policy to a group Anthem Blue Cross Blue Shield plan;
- Change employers and both have Anthem Blue Cross Blue Shield coverage; or
- Are a new Member of the Group who joins the Group after the Group's initial enrollment with Anthem. Such new Members will receive credit from their prior carrier as described in the Portability section.

Delivery of Documents

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

Notice of Ineligibility

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

Notice of Changes

The Subscriber is responsible to notify the Group of any changes which will affect his or her

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

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 31 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage.

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

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

Effective Date Of Coverage

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

6 TERMINATION, CONTINUATION, CONVERSION

Termination

Except as otherwise provided, your coverage may terminate in the following situations. The

information provided below is general and the actual effective date of termination may vary

based on your Group's agreement with Us and your specific circumstances, such as whether premium has been paid in full:

- If you terminate your coverage, termination will generally be effective on the last day of the billing period in which We received your notice of termination.
- Subject to any applicable continuation requirements, if you cease to meet eligibility requirements as outlined in this Certificate, your coverage generally will terminate on the last day of the billing period. The Group and/or you must notify Us immediately if you cease to meet the eligibility requirements. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan or under any other non-Anthem plan which is offered by, through or in connection with the Group as an option instead of this Plan, then coverage for you and your Dependent will generally terminate at the end of the billing period for which premium has been paid, subject to the consent of the Group. The Group agrees to immediately notify Us that you have elected coverage elsewhere.
- A Dependent's coverage will generally terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent.
- If coverage is through an association, coverage will generally terminate on the date membership in the association ends.
- If you engage in fraudulent conduct or furnish Us fraudulent or misleading material information relating to claims or application for coverage, then We may terminate your coverage. Termination is generally effective 31 days after Our notice of termination is mailed. You are responsible to pay Us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services. We will also terminate your Dependent's coverage, generally effective on the date your coverage was terminated. We will notify the Group in the event We terminate your and your Dependent's coverage.
- If you fail to pay or fail to make satisfactory arrangements to pay any amount due to Us or Providers (including the failure to pay required Deductibles and/or Copayments), We may terminate your coverage and may also terminate the coverage of all your Dependents, generally effective immediately upon Our written notice to the Group.
- If you permit the use of yours or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice to the Group. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for the Maximum Allowable Amount for services received through such misuse.
- You will give Anthem at least five (5), working days advance notice of any Subscriber's termination from the Group, in order to enable Anthem to remove the Subscriber and/or his Dependents from Anthem's list of Members. Further, if Anthem has provided benefits for persons no longer eligible because Anthem did not receive timely notification of termination, then you shall reimburse Anthem for all unrecovered claim amounts paid.
- In the event that a Member is no longer eligible for coverage and has been terminated from the coverage, and after the effective date of termination Anthem (or its subcontracted vendors) makes payment of any claims which would otherwise have been payable under the terms of this Certificate but for the fact that the claims were incurred after the effective date of

termination, the Member shall be liable to reimburse Anthem for all unrecovered claim amounts paid.

- If a Member dies while this Certificate is in Force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or the estate when notice of the death is provided within 12 months of the date of death.

No coverage shall be in force and no benefit shall be payable for charges which are incurred after the date a Subscriber's coverage terminates for any reason under this Plan, except as provided by COBRA.

Certification of Coverage

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

Misstatement of Age

The Group and/or Subscriber is liable to the Plan for the full difference between what was paid for coverage rated on an incorrect statement of age and what is owed for coverage given the correct age.

Reinstatement

You will not be reinstated automatically if coverage is terminated. Re-application is

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

Federal Continuation of Coverage (COBRA)

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

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

COBRA Continuation Coverage

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

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage

under the Group's health plan because either one of the following qualifying events happens:

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

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

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

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

- The parent-Subscriber dies;
- The parent-Subscriber's hours of employment are reduced;
- The parent-Subscriber's employment ends for any reason other than his or her gross misconduct;
- The parent-Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or

The child stops being eligible for coverage under the Group's health plan as a "Dependent child."

If Your Group Offers Retirement Coverage

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

When is COBRA Coverage Available

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided

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

COBRA continuation coverage is a temporary continuation of coverage.

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

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Group's health plan is determined by the Social Security Administration to be disabled and you notify the Group in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The

disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

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

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

If You Have Questions

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

7 HOW TO OBTAIN COVERED SERVICES

Benefits are provided when you obtain Covered Service from Providers. We may inform you for Section 2 Major Medical benefits that it is not Medically Necessary for you to receive services from a Provider or remain in a Hospital or other Facility. This decision is made upon review of your condition and treatment and Medicare's or Our determination of Medical Necessity. You may appeal this decision. See Complaint and Appeals Procedures in the General Provisions section of this Certificate.

Not Liable for Provider Acts or Omissions

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

give anyone any claim, right, or cause of action against the Plan based on what a Provider of health care, services or supplies, does or does not do.

Identification Card

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

8 HEALTH CARE MANAGEMENT

Health Care Management is applicable for Section 2 Major Medical benefits.

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

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Members by reviewing the use of appropriate procedures, setting (place of service), and resources through Case Management.

Your rights to benefits for Covered Services provided under this Certificate is subject to certain policies, guidelines, and limitations, including, but not limited to, Our clinical coverage guidelines, Medical Policy and Health Care Management feature listed in this section.

A description of the Health Care Management feature, its purpose, requirements and effects on benefits is provided in this section.

Case Management (includes Discharge Planning)

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

Clinical Coverage Guidelines

Our clinical coverage guidelines, such as medical policy, and preventive care clinical guidelines, reflect the standards of practice and medical interventions identified as reflecting appropriate medical practice. The purpose of Clinical Coverage Guidelines is to assist in the

interpretation of Medical Necessity. However, the Certificate and Group Contract take precedence over the clinical coverage guidelines. Medical technology and standards of care are constantly changing and We reserve the right to review and update the clinical coverage guidelines periodically.

9 COVERED SERVICES

SECTION 1 - MEDICARE COMPLEMENTARY BENEFITS

This section describes the benefits available when Medicare has made payment for a Medicare Eligible Expense. We will cover the amount Medicare determines is your liability for Medicare Eligible Expenses.

The amounts We pay and the benefits covered are as follows:

MEDICARE PART A

Medicare Part A Deductible

Medicare Part A requires you to pay a Deductible each Medicare Benefit Period before it pays for Hospital expenses. See your Schedule of Benefits for coverage of the Part A Deductible and any benefit limitations.

Hospital Inpatient Services

Medicare Part A requires you to pay certain Medicare Coinsurance amounts during your Hospital stay beginning on the 61st day and ending after the 90th day in any Medicare Benefit Period. We will pay the Medicare Coinsurance. See your Schedule of Benefits for any benefit limitations.

Medicare Part A requires you to pay certain Medicare Coinsurance amounts during your Hospital stay during the use of Medicare's sixty lifetime reserve days. We will pay the Medicare

Coinsurance. See your Schedule of Benefits for any benefit limitations.

If you exhaust Your Medicare Part A Hospital benefits (including your reserve lifetime days), after the 90th day We will pay the Medicare Eligible Expenses up to the Plan maximum of an additional 365 days. See your Schedule of Benefits for any benefit limitations.

Skilled Nursing Facility Services

Medicare Part A pays for Medicare Eligible Expenses you receive in a Skilled Nursing Facility in full for the first 20 days in a semi-private room. We will pay the Medicare Part A Coinsurance from the 21st through the 100th day in a Skilled Nursing Facility care. **NOTE: See Major Medical Benefits in this booklet for Skilled Nursing Facility Services after the 100th day.**

Home Health Care

We will pay the Medicare Coinsurance. See your Schedule of Benefits for any benefit limitations.

Medicare Part A Blood

We will pay for the first three pints of blood Medicare requires you to pay. See your Schedule of Benefits for any benefit limitations.

Hospice Care

We will pay the Medicare Coinsurance for Outpatient drugs while in a Hospice and Inpatient

respite care (care given to a Hospice patient so that the usual caregiver can rest). See your Schedule of Benefits for any benefit limitations.

MEDICARE PART B

Medicare Part B Deductible

Medicare Part B requires you to pay a Deductible each calendar year before it pays for Physician or other Provider services. See your Schedule of Benefits for coverage of the Part B Deductible and any benefit limitations.

Medical Services

Medicare Part B covers services you receive from Physicians and other Medicare approved Providers. These include independent laboratories, ambulance services, and independent physical therapists. Some Hospital services are also covered under Part B.

Medicare Part B requires you to pay certain Medicare Coinsurance amounts for Part B Eligible Expenses. We will pay the Medicare Coinsurance. See your Schedule of Benefits for any benefit limitations.

Medicare Part B Excess Charges (non-assigned claims only)

Coverage for the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge. See your Schedule of Benefits for any benefit limitations.

Medicare Part B Blood

We will pay for the first 3 pints of blood Medicare requires you to pay and the Medicare Coinsurance. See your Schedule of Benefits for any benefit limitations.

Outpatient (non-Hospital) Treatment of Mental Health Conditions

We will pay the Medicare Coinsurance. See your Schedule of Benefits for any benefit limitations.

Outpatient (non-Hospital) Physical Therapy including Speech and Occupational Therapy

We will pay the Medicare Coinsurance. See your Schedule of Benefits for benefit limitations.

SECTION 2- MAJOR MEDICAL BENEFITS

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

We will not pay benefits under Section 2 Major Medical for services paid or payable by Medicare or by Us as described above or in the Schedule of Benefits for Section 1 Medicare Complementary benefits.

You are responsible for any balance due between the Provider's charge and the Maximum Allowable Amount in addition to any Copayments, Deductibles, and non-covered charges.

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

Medical Necessity, Experimental/Investigative services and new technology on Our Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

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

NOTE: Anthem will use its own standards for determining Medical Necessity and Experimental/Investigative services, not Medicare's, for Covered Services eligible under Section 2 Major Medical Benefits.

In addition to the services listed below, Covered Services include other Medicare eligible and ineligible services that Anthem determines to be Medically Necessary and not Experimental or Investigational in nature.

Inpatient Services

Inpatient Services do not include care related to Mental Health Conditions, except as specified. Inpatient Services include:

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

Room, Board, and General Nursing Services

- a room with two or more beds;

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

Ancillary Services

- operating and treatment rooms and equipment;
- prescribed drugs;
- anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider;
- medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services; and
- Therapy Services.

Professional Services

- **Medical care visits** limited to one visit per day by any one Physician.
- **Intensive medical care for** constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules are excluded.
- **Surgery and the administration of general anesthesia.**

Skilled Nursing Facility (SNF)

Room and Board

Benefits begin on the 101st day. Covered rooms are semi-private and private. See your Schedule of Benefits for benefit limitations.

Ancillary

Covered charges for SNF ancillaries, including Diagnostic Services.

NOTE: After Medicare's benefits are exhausted, the Plan's Medical Policy Committee must review Skilled Nursing Facility services to determine whether they meet the Plan's Skilled Care guidelines.

Ambulance Services

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

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

Ambulance services are a Covered Service only when Medically Necessary, except When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for

trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

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

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

Reconstructive Services

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

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

- Cleft lip;
- Cleft palate.

Substance Abuse

Outpatient Facility Services and Physician Office Services for the treatment for Substance Abuse are covered for the diagnosis, crisis intervention and short term treatment for detoxification and/or rehabilitation of Substance Abuse. Copayments are specified in the Schedule of Benefits.

Medically Necessary Services In A Foreign Country

Benefits paid for treatment provided outside the United States, if the treatment received meets all but the geographical requirement for payment of Medicare benefits. See your Schedule of Benefits for benefit limitations. This benefit does not apply to home health care.

Travel outside the country:

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

Home Health Care

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

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

Home IV Therapy Drugs/Injectable Drugs

Covered Services are Injectable drugs when ordered by a Physician, intravenous antibiotic therapy, total parenteral nutrition, enteral nutrition (when only source of nutrition), hydration therapy, solutions, additives, and intravenous pain management. Services must be provided by a retail pharmacist, a licensed medical supply company, or a home health care Provider. A Physician's prescription must be included for each drug to be covered.

Private Duty Nursing

Covered Services are for non-custodial nursing care by a RN or LPN, when you have been referred by a Physician.

Visiting Nurse's Association

Covered Services are for direct patient care in the home, including:

- Health supervision;
- Education; and
- Counseling.

Services performed by RNs, LPNs, and other personnel such as home health aides, dieticians, and therapists are covered.

Dental Services

Related to Accidental Injury

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

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

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;

- Oral surgery;
- Mandibular/maxillary reconstruction;
- Anesthesia.

Dental Care

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

Routine Physical Examinations

Routine or periodic exams including related diagnostic testing (e.g., pelvic exams, pap smears). Having the right exams at the right times may help you avoid serious illness. Check with your Provider for specific health guidelines based on your age and family history.

Family history, current health problems and lifestyle all affect your risk for disease. Talk to your Provider to determine if you are at high risk for specific diseases and then together determine your appropriate exam schedule.

Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, are not covered.

Hearing Tests

Covered Services are for one hearing examination. See Schedule of Benefits for any limitations.

Dental Services

Preventive dental services are covered. See your Schedule of Benefits for benefit limitations.

Medical Foods

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

State Mandated Benefits

These benefits are required to be covered by group health plans in Indiana; they will usually be paid Medicare and Section 1 Medicare Complementary Benefits, but will be paid under Section 2 Major Medical to the extent not paid by Medicare:

Mastectomy Notice

Services for reconstructive surgery following mastectomies are covered including coverage for:

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

All applicable benefit provisions apply, including Deductibles, Copayments and/or co-insurance

Diabetes Self Management Training

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

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

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

Mammography Screening Services

Benefits are paid for routine screening mammography services. Benefits will also be paid for additional mammography views required for proper evaluation and any ultrasound services for screening of breast cancer, if such services are determined to be Medically Necessary by your Physician.

Prostate Screening Services

Benefits are paid for individual routine prostate screening services, including services provided in a Physician's office.

Colorectal Cancer Testing

Benefits for routine colorectal cancer examinations and related laboratory tests for cancer, including services provided in a Physician's office are covered. Examinations and tests will be covered as often as recommended by the current American Cancer Society guidelines or by your Physician.

Morbid Obesity Treatment Services

Covered Services include surgical treatment of morbid obesity:

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

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

- save the life of the Member; or

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

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

"Morbid obesity" means:

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

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

10 EXCLUSIONS

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. **We are the final authority for determining if services or supplies are Medically Necessary, or Experimental/Investigative, under Section 2 Major Medical Benefits.**

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

1. Which We or Medicare determine are not Medically Necessary or do not meet Our Medical Policy, clinical coverage guidelines, or benefit policy guidelines;

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

2. Charges in excess of the Maximum Allowable Amount;
3. Received from an individual or entity that is not a Provider, as defined in this Certificate, or recognized by Us;
4. Supportive devices of the feet; care of flat feet, fallen arches, weak feet, chronic foot strain, and toenails; and treatment of corns,

- bunions, and calluses except when Medically Necessary including but not limited to foot care for diagnosis of diabetes or for impaired circulation to the lower extremities.
5. Treatment of an injury or illness resulting from participating in a riot.
 6. Charges related to suicide or attempted suicide.
 7. Treatment of intentionally self-inflicted injuries.
 8. Treatment of an injury sustained while flying, except as a fare paying passenger in a regularly scheduled commercial aircraft.
 9. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).
 10. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. this exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
 11. Services or supplies to the extent you are not legally obligated to pay for them.
 12. Services provided by any governmental agency to the extent that you are not charged for them, except when this exclusion conflicts with state or federal law.
 13. Services or supplies prescribed, ordered, or referred by, or received from, a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
 14. Services or supplies received from a dental or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group.
 15. Services and supplies for dental care, except as specifically stated as covered.
 16. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery including but not limited to cataract surgery, or for soft contact lenses due to a medical condition.
 17. For Custodial Care, domiciliary or convalescent care, whether or not recommended or performed by a professional.
 18. Rest cures or sanatorium care.
 19. Preventive or routine care, including physicals, premarital examinations, and any other routine or periodic examinations, except as specifically stated as covered.
 20. Travel, whether or not recommended by a Physician.
 21. Prescription drugs.
 22. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Anthem and/or Medicare.
 23. Services or supplies that do not qualify for payment under Medicare, unless specifically stated as covered.

24. Any New FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, and/or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, is excluded from coverage for the first 6 months after the date the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may, in its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
25. Related to weight loss or weight loss programs whether or not they are under medical or Physician supervision. Weight loss programs for medical reasons are excluded, except certain surgical treatments of morbid obesity as required by law are Covered Services. Weight loss programs include but are not limited to commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.
26. Services and supplies related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction; prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.
27. Services and supplies related to the treatment of abuse of nicotine from tobacco or other sources.
28. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by Anthem.
29. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST) and iridology-study of the iris.
30. For personal hygiene, environmental control, or convenience items including but not limited to: air conditioners; humidifiers; physical fitness equipment; personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals; charges for failure to keep a scheduled visit; for non-medical self-care except as otherwise stated; purchase or rental of supplies for common household use, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program; for a health spa or similar facility.
31. For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
32. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
33. Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply for left ventricular assist devices (LAVD) when used as a bridge to a heart transplant.

34. Services or supplies that do not qualify for payment under Medicare, unless specifically stated as covered under Section 2 Major Medical or Anthem determines it to be Medically Necessary and not Experimental or Investigational in nature.
35. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
36. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
37. Treatment of telangiectatic dermal veins (spider veins) by any method.
38. Reconstructive services except as specifically stated in the Covered Services section of this Certificate, or as required by law.

11 CLAIMS PAYMENT

How to Obtain Benefits

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

Services Performed During Same Session

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

How Benefits Are Paid

Medicare Complementary Benefits Received in Indiana

If you are a patient at any Medicare participating Hospital, your Medicare Part A and Major Medical claims will be filed for you if you show both Identification Cards.

Most doctors and other Providers will also file your Medicare Part B and Major Medical claims for you if you show both Identification Cards. Make sure your identification number is shown on the appropriate line of the Medicare claim form.

Occasionally, you may have to file your claims yourself. Indicate your identification number on the appropriate line of the Medicare claim form, and your Major Medical will be processed automatically. After your Medicare benefits have been paid, Medicare will send you an explanation of what they paid and why. Shortly thereafter, you will receive notice indicating what We paid and why.

Medicare Complementary Benefits Received outside of Indiana

Medicare claims must be filed with the Medicare carrier in the state in which the services were performed. The Medicare carrier in that state will send you an Explanation of Medicare Benefits, explaining what Medicare paid. When you receive that explanation, send a copy of it, an itemized statement of charges, and all the numbers on your Identification Card to:

Anthem Blue Cross and Blue Shield
P. O. Box 37010
Louisville, KY 40233-7010

Major Medical

This Plan shares the cost of your medical expenses with you up to the Maximum Allowable Amount. For services subject to a Deductible, you pay a portion of the bill before this Plan begins to pay its share of the balance. Some services are subject to a Copayment, others may be subject to both a Deductible and Copayment.

Many Providers will seek compensation from Us for Covered Services. When using a Provider you are only responsible for Copayments, Deductibles, and non-covered charges. Providers have agreed to accept the Maximum Allowable Amount as payment in full. Copayments are your share of the cost for particular health services, and are generally due at the time you receive the medical service. For Covered Services subject to a Copayment, you pay a portion of the bill and the Plan pays its share of the balance. Refer to the Schedule of Benefits to see what Copayment amount is required for each Covered Service.

The amount you pay may differ by the type of service you receive or by Provider. Refer to the Schedule of Benefits to see what amount you are required to pay for each service. Claims for Covered Services need not be sent to Us in the same order that expenses were incurred.

We will deny that portion of any charge which exceeds the Maximum Allowable Amount.

Payment of Benefits

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

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

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

Assignment

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

Notice of Claim

We are not liable under the Certificate, unless We receive written notice that Covered Services have been given to you. The notice must be given to Us by December 31 of the year following that you received the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law. If we have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice by December 31 of the year following that you received the Covered Services will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year from December 31 of the year following that you received the Covered Services, and no request for an adjustment of a claim can be submitted later than

24 months after the claim has been paid.

Claim Forms

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

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

Proof of Claim

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

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need

to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

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

Appeals Procedure

You or your Physician may request a review of a Hospital Inpatient admission, length of stay, procedure, service, level of care, or place of care that was not certified. The Company shall utilize a Physician who did not participate in the original determination not to certify. A decision regarding the Appeal will be completed within the days allowed by law after all information necessary to complete the review has been received.

Your Choice of Providers

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

Member's Cooperation

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

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB

is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

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

12 GENERAL PROVISIONS

Entire Contract

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

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

Form or Content of Certificate

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

endorsement authorized and signed by an officer of the Plan.

Disagreement with Recommended Treatment

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

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative

exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

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

Coordination of Benefits

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

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

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary

Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

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

COB DEFINITIONS

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

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for

accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

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

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

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

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

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

The following are non Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.

6. The amount that is subject to the Primary high-deductible health plan's deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
7. Any amounts incurred or claims made under the Prescription Drug program of This Plan.

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

1. Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that

are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

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

Rule 1 - Non-Dependent or Dependent.

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

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

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

- If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
 - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
 - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The Plan covering the Custodial parent;
 - The Plan covering the spouse of the Custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would

hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

Allowable expense for that claim.

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

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

Duplicate Coverage

No Member whose coverage is in effect may also have coverage under an individual health insurance contract with Us. You may not have an individual Medicare Supplement policy and this Plan. A Member who has such duplicate coverage may keep only one coverage. A Member who chooses not to keep this coverage will receive a refund of any applicable Premium payments that apply to the period of duplicate coverage, minus benefits paid for expenses he or she incurred during the refund period.

Duplicate Payment

If you incur an expense that can be covered under more than one benefit in this Plan, We will not duplicate payment under the various benefits available. However, consecutive payments for Covered Services will be provided as appropriate.

Worker's Compensation

The benefits under this Certificate are not designed to duplicate any benefit for which Members are eligible under the Worker's

Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Other Government Programs

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

Subrogation and Right of Reimbursement

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

Subrogation

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

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.

- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

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

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
 1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
 2. you fail to cooperate.
- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the Providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and We would not have any obligation to pay the Provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

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

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

Relationship of Parties (Group-Member-Plan)

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

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

Interpretation of Certificate

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

Conformity with 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

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

contracting and the legal representatives of all Members incapable of contracting agree to all terms, conditions, and provisions hereof.

Clerical Error

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

Medical Examination

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

Medical Services

We are not liable for the furnishing of Covered Services, but merely for the payment of them. You shall have no claim against Us for acts or omissions of any Provider from whom you receive Covered Services. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Legal Action

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

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

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

Provider Reimbursement

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

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

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

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

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

Policies and Procedures

The Plan is able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Certificate more orderly and efficient. Members must follow and accept any new policies, procedures, rules and interpretations.

Under the terms of the Group Contract, the Plan has the authority, in its sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Certificate. The Plan reserves the right to discontinue a pilot or test program at any time. The Plan will provide thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Waiver

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

Plan's Sole Discretion

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

Reservation of Discretionary Authority

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

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

Member may utilize all applicable Member Grievance procedures.

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

Anthem Insurance Companies, Inc. Note

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

13 MEMBER GRIEVANCES

Grievances

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

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

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

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

available to assist you at least 40 normal business hours per week.

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

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

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

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

not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

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

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

Appeals

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

Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

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

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

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

External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance . To qualify for an External

Grievance all of the following requirements must be met:

- Your Appeal is regarding:
 1. an adverse determination of appropriateness; or
 2. an adverse determination of medical necessity; or
 3. a determination that a proposed service is Experimental/Investigational made by Us or an agent of Ours regarding a service proposed by the treating physician; and
- You or your representative request the External Grievance in writing within forty-five (45) days after You are notified of the Appeal panel's decision concerning your Appeal; and
- The service is not specifically excluded in this Certificate.

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

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is received by Us after the end of the calendar year

plus 12 months have passed since the incident leading to your Grievance. We will accept Appeals filed within 60 days after you are notified of our decision concerning your Grievance. We will accept External Grievance requests filed within 45 days after you are notified of our Appeal decision.

Grievances and Appeals by Members of ERISA Plans

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

Department of Insurance

Notice To Members

Questions regarding your coverage should be directed to:

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

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

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

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

Complaints can be filed electronically at
www.in.gov/idoi.

AICBL-RET01

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.
An independent licensee of the Blue Cross and Blue Shield Association.
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Underwritten by Anthem Insurance Companies, Inc.

Your Vision Certificate

Vision Certificate of Coverage

(herein called the "Certificate")

Blue View Vision

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

CERTIFICATE

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

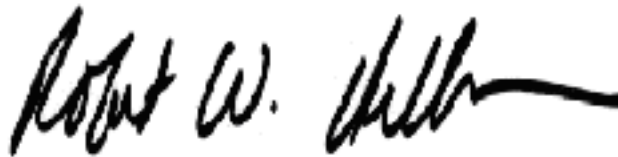
The coverage described in this Certificate is subject in every respect to the provisions of the Group Contract issued to the Group. The Group Contract and this Certificate and any amendments or riders attached to the same, shall constitute the Group Contract under which Covered Services and supplies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

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

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

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

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



President

**Questions regarding your policy or coverage should be directed to:
Anthem Blue Cross and Blue Shield**

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

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at www.in.gov/idoi.

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1 SCHEDULE OF BENEFITS

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

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

DEPENDENT AGE LIMIT To the end of the month in which the child attains age 26

COVERED SERVICES	COPAYMENT/MAXIMUMS	
	Network	Non-Network
Exam	\$5 Copayment	Reimbursed up to \$42
Limited to one exam per Member every 12 months.		

Prescription Lenses (including factory scratch coating polycarbonate lenses for children under 19 years old and Photochromic lenses for children under 19 years old.)	\$20 Copayment	
Basic Lenses (Pair)		
• Single Vision Lenses		Reimbursed up to \$40
• Bifocal Lenses		Reimbursed up to \$60
• Trifocal Lenses		Reimbursed up to \$80

Limited to one set of lenses per Member every 12 months

Frames (Limited to one set of frames per Member every 24 months)	\$0 Copayment	Any frame up to \$130 retail	Reimbursed up to \$45
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Prescription Contact Lenses

(traditional or disposable)

- **Non-Elective Contact Lenses** (Availability once every 12 months) \$0 Copayment Non-Elective Contact Lenses are Reimbursed up to \$210

- **Elective Contact Lenses** \$0 Copayment Elective Contact Lenses are Reimbursed up to \$105
(Availability once every 12 months) Elective contact lenses are reimbursed up to \$130

Note: If you chose covered Non-Elective Contact Lenses or Elective Contact Lenses, no benefits will be available for covered eyeglass lenses and frames in that period.

Laser Vision Correction Services

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

2 DEFINITIONS

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

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

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

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

Group Contract.

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

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

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

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

- Within the Maximum Allowable Amount;
- Not specifically excluded or limited by the Certificate;
- Specifically included as a benefit within the Certificate.

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

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

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

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

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

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

Family Coverage - Coverage for the Subscriber and eligible Dependents.

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

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

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

Last Date of Service - The period of time in which benefits are tracked. The Member must wait until the specific interval from the last date

of service to receive Covered Services as listed in the Schedule of Benefits.

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

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

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

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

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

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

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

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

Non-Elective Contact Lenses - Contact Lenses which are provided for reasons that are not

cosmetic in nature. Non-Elective Contact Lenses are Covered Services when the following conditions have been identified or diagnosed:

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

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

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

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

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

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

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

3 ELIGIBILITY AND ENROLLMENT

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

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

Eligibility

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

Subscriber

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

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

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by

the Subscriber, meet all Dependent eligibility criteria established by the Group and be:

- The Subscriber's spouse. For information on spousal eligibility please contact the Group.
- The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same sex who has signed the Domestic Partner Affidavit certifying that: he or she is the Subscriber's or the Eligible Person's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor Eligible Person is related by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber or Eligible Person.
 - For purposes of this Certificate, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.
 - Any federal or state law which applies to a Member who is a spouse or child under this Certificate shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Certificate. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.
 - To apply for coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.
- The Subscriber's or the Subscriber's spouse's natural children, newborn and legally adopted children, stepchildren, children for whom the Subscriber or the Subscriber's spouse is a legal guardian, or children who the Group has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.
- The following children, if the Subscriber provides more than fifty percent (50%) of the child's total support: the Subscriber's or the Subscriber's spouse's grandchildren or other blood relatives.

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

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

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

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

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

College Student Medical Leave

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

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

Enrollment

Initial Enrollment

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

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

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

Newborn and Adopted Child Coverage

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

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

To continue coverage beyond the 31 day period after the child's birth or adoption you must notify Us by submitting a Change of Status Form to add the child under the Subscriber's Certificate. The Change of Status Form must be submitted within 31 days after the birth or placement of the child. If timely notice is given, an additional Premium for the coverage of the newborn child or adopted child will not be charged for the duration of the notice period. However, if timely notice is not given, We may charge an additional Premium from the child's date of birth or placement for adoption. Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure We have accurate records and are able to cover your claims.

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

Adding a Child due to Award of Legal Custody or Guardianship

If a Subscriber or the Subscriber's spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage would start on the date the court granted legal custody or guardianship. If We do not receive an application

within the 31-day period, the child will be treated as a Late Enrollee.

Qualified Medical Child Support Order

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

Special Enrollment/Special Enrollees

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your other coverage ends (or within 60 days after Medicaid coverage ends) after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Plan, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If We receive an application to add your Dependent or an Eligible Person and Dependent

more than 31 days after the qualifying event, that person is only eligible for coverage as a Late Enrollee. Application forms are available from the Plan.

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

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

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

Application forms are available from the Plan.

Open Enrollment Period

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

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

Notice of Changes

The Subscriber is responsible to notify the Group of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Certificate. The Plan must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death,

change of Dependent disability or dependency status, enrollment or disenrollment in another vision plan. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of payments from the Group for persons no longer eligible for services will not obligate Us to pay for such services.

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

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

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

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender or age.

Effective Date of Coverage

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

Statements and Forms

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

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

Delivery of Documents

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

Contestability

Your policy shall not be contested except for nonpayment of premium, after it has been in force for two (2) years from its date of issue; and no statement made by a person shall be used in contesting the validity of the insurance unless it is contained in a written instrument signed by the person making such statement.

4 TERMINATION, CONTINUATION AND CONVERSION

Termination

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the

actual effective date of termination may vary based on your Group's agreement with Us and your specific circumstances, such as whether Premium has been paid in full:

- If you terminate your coverage, termination will generally be effective on the last day of the billing period in which We received your notice of termination.
- Subject to any applicable continuation or conversion requirements, if you cease to meet eligibility requirements as outlined in this Certificate, your coverage generally will terminate on the last day of the billing period. The Group and/or you must notify Us immediately if you cease to meet the eligibility requirements. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you engage in fraudulent conduct or furnish Us fraudulent or misleading material information relating to claims or application for coverage, then We may terminate your coverage. Termination is generally effective 31 days after Our notice of termination is mailed, except when indicated otherwise in the Schedule of Benefits. We will also terminate your Dependent's coverage, generally effective on the date your coverage is terminated. We will notify the Group in the event We terminate you and your Dependent's coverage.
- A Dependent's coverage will generally terminate the last day of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent, except when indicated otherwise in the Schedule of Benefits.
- If coverage is through an association, coverage will generally terminate on the date membership in the association ends.
- If you elect coverage under another carrier's vision benefit plan or under any other non-Anthem plan which is offered by, through, or in connection with the Group as an option instead of this Certificate, then coverage for you and your Dependents will generally terminate at the end of the billing period for which Premium has been paid, subject to the consent of the Group. The

Group agrees to immediately notify Us that you have elected coverage elsewhere.

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

Removal of Members

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

Reinstatement

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

Continuation

Federal Continuation of Coverage (COBRA)

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

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health plan. It can

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

COBRA Continuation Coverage

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

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

If Your Group Offers Retirement Coverage

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

When is COBRA Coverage Available

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided

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

How Long Will Continuation Coverage Last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued only for up to a total of 18 months. In the case of losses of coverage due to the Subscriber's death, divorce or legal separation, the Subscriber's becoming entitled to Medicare benefits or a Dependent child ceasing to be a Dependent under the terms of the Group's health plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or

reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement.

How Can You Extend The Length of COBRA Continuation Coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Group of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

- **Disability**

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. You must provide the SSA determination of your disability to the Group within 60 days of receipt. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Group of that fact within 30 days after SSA's determination.

- **Second Qualifying Event**

An 18-month extension of coverage will be available to spouses and Dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage

available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered Subscriber, divorce or separation from the covered Subscriber, the covered Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Group's health plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Group within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Trade Act of 1974

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

Premiums and the End of COBRA Coverage

Premium will be no more than 102% of the Group rate (unless your coverage continues beyond 18 months because of a disability. In that case, premium in the 19th through 29th months may be 150% of the Group rate).

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan,

- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the Group ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Group would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Other coverage options besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

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

Continuation of Coverage Due To Military Service

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

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

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

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

1. The 24-month period beginning on the first date of your absence from work; or
2. The day after the date on which You fail to apply for or return to a position of

employment.

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

Family and Medical Leave Act of 1993

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

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

5 HOW TO OBTAIN COVERED SERVICES

Network Services and Benefits

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

We may inform you that a service you received is not a Covered Service under the

Certificate. You may appeal this decision. See the Complaint and Appeals Procedures section of this Certificate.

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

Non-Network Services and Benefits

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

Relationship of Parties (Plan - Network Providers)

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

The Plan shall not be responsible for any claim or demand on account of damages arising

out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Provider or in any Provider's facilities.

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

Not Liable for Provider Acts or Omissions

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

6 COVERED SERVICES

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

The following are Covered Services:

- Routine Eye exam
- Standard Eyeglass Lenses
- Frames
- Contact Lenses in lieu of Eyeglass Lenses

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

If you choose a set of frames that are valued at more than the Maximum Allowable Amount, you are responsible for the difference in cost.

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

Routine Eye Exam

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

- Case history
- Recording corrected and uncorrected visual acuity
- Internal exam
- External exam
- Pupillary reflexes
- Binocular vision
- Objective refraction
- Subjective refraction
- Glaucoma test
- Slit lamp exam (Biomicroscopy)
- Dilation
- Color vision
- Depth perception
- Diagnosis and treatment plan.

Eyeglass Lenses

Eyeglass Lenses are available in standard or basic plastic (CR39) Lenses including single vision, bifocal, and trifocal with factory coating with polycarbonate lenses for children under 19 and photochromic lenses for children under 19. If you choose progressive Lenses that are no line bifocals, there will be an additional cost. All eyeglass Lenses are subject to the applicable Copayment listed in the Schedule of Benefits. There may also be an additional cost for any add-ons to the Lenses such as anti-reflective coating or ultra-violet coating. These and any other lens add-ons may be discounted according to Our Additional Savings Program.

Frames

The frame allowance is based upon the retail cost. The Member may apply the plan allowance toward the Network Provider's selection of frames. The Schedule of Benefits lists the frames

allowance available under your plan. If you choose a set of frames that are valued at more than the Maximum Allowable Amount, you are responsible for the balance based upon the Additional Savings Program.

Elective Contact Lenses

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

Non-Elective Contact Lenses

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

Eligibility

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

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

Fitting Fees

The Member is responsible for 100% of the fitting fee at the time of service. However, Our Maximum Allowable Amount reimbursement paid to the prescribing Provider for Non-Elective Contact Lenses may include a portion, or all, of the fitting fee. Any remaining amount will be applied to the Provider's fitting fee.

SPECIAL 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.

Cosmetic Options

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

- Blended Lenses
- Contact Lenses (except as noted herein)
- Oversize Lenses
- Progressive multifocal Lenses
- Photochromatic Lenses, or tinted Lenses
- Coated Lenses
- Frames that exceed the Maximum Allowable Amount
- Cosmetic Spectacle Lenses
- Ultra-violet coating
- Scratch resistant coating
- Polycarbonate Lenses
- Anti-reflective coating
- Optional cosmetic items

7 EXCLUSIONS

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

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

1. Received from an individual or entity that is not a Provider, as defined in this Certificate.
2. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This

exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

3. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
4. For illness or injury that occurs as a result of any act of war, declared or undeclared.
5. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
6. For which you have no legal obligation to pay in the absence of this or like coverage.
7. Received from an optical or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.

8. Prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
9. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
10. For missed or canceled appointments.
11. In excess of Maximum Allowable Amount.
12. Incurred prior to your Effective Date.
13. Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.
14. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
15. For sunglasses and accompanying frames.
16. For safety glasses and accompanying frames.
17. For inpatient or outpatient hospital vision care.
18. For Orthoptics or vision training and any associated supplemental testing.
19. For non-prescription lenses.
20. For two pairs of glasses in lieu of bifocals.
21. For Plano lenses (lenses that have no refractive power).
22. For medical or surgical treatment of the eyes.
23. For lost or broken Lenses or frames, unless the Member has reached his or her normal interval for service when seeking replacements.
24. For services or supplies not specifically listed in the Certificate.
25. Certain brands on which the manufacturer imposes a no discount policy.
26. For services or supplies combined with any other offer, coupon or in-store advertisement.

8 CLAIMS PAYMENT

Obtaining Services/Claim Payment

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

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

- The patient's name, birthdate and relationship to the Member

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

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

Assignment

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

written consent of the Plan, except as described in this Certificate.

Notice of Claim

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

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

Claim Forms

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

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

Proof of Claim

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

Time Benefits Payable

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

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

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental

program. Any Member who fails to cooperate will be responsible for any charge for services.

Explanation of Benefits

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

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

9 GENERAL PROVISIONS

Entire Contract

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

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

Form or Content of Certificate

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

Circumstances Beyond the Control of the Plan

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

Coordination of Benefits

We consider this Plan primary in all circumstances.

Other Government Programs

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

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 12 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

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

Relationship of Parties (Group-Member-Plan)

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

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

Conformity with Law

Any provision of this Plan that is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Modifications

This Certificate allows the Group to make the Plan coverage available to eligible Members. However, this Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Group Contract, or by mutual agreement between the Plan and the Group without the permission or involvement of any Member. Changes will not be effective until 30 days after We provide written notice to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting the Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Certificate.

Physical Examination and Autopsy

We shall have the right to: (1) examine any Member for whom a claim is made when and as often as may be reasonably required during the pendency of a claim; and (2) perform an autopsy on any Member where it is not otherwise prohibited by law.

Clerical Error

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

Legal Action

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

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

You must exhaust the Plan's Complaint and Appeals Procedures before filing a lawsuit or other legal action of any kind against Us.

Policies and Procedures

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

Waiver

No agent or other person, except an authorized officer of the Plan, is able to disregard any conditions or restrictions contained in this Certificate, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, in its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if the Plan determines such services and supplies are in lieu of more

expensive services and supplies, which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

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

The Plan, or anyone acting on Our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, We, or anyone acting on Our behalf, has complete discretion to determine the administration of Your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are covered. However, a Member may utilize all applicable Grievance and Appeals Procedures.

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

Anthem Blue Cross and Blue Shield Note

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding

that this Certificate constitutes a contract solely between the Group and Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield

plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

10 COMPLAINT AND APPEALS PROCEDURES

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

- Your coverage and benefit levels, including Copayment amounts;
- Specific claims or services you have received;
- Providers in the Network; and/or
- Provider directories.

You will be notified, in writing, if a claim or other request for benefits is denied in whole or in part. If such a request is denied, the notice of denial will explain why benefits were denied and describe your rights under the Appeals Procedure. A Complaint Procedure also exists to help you understand the Plan's determinations.

The Complaint Procedure

A Complaint Procedure is available to provide reasonable, informative responses to complaints that you may have concerning the Plan. A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Plan of its procedures and contracts. The Plan invites you to share any concerns that you may have over benefit determinations, coverage cancellations, or the quality of care rendered by Vision Providers in the Plan's Networks.

If you have a complaint or problem concerning benefits or services, please contact Us. Please refer to your Identification Card for Our address and telephone number. You may submit your complaint by letter or by telephone call. Or, if you wish, you may meet with your local service representative to discuss your complaint.

Members are encouraged to file complaints within 60 days of an initial, adverse action, but must file within six months after receipt of notice of the initial, adverse action. The time required to review complaints does not extend the time in which appeals must be filed.

The Appeals Procedure

An appeal is a formal request from you for the Plan to change a previous determination. If you are notified in writing of a Coverage Denial or any other adverse decision by Us, you will be advised of your right to an internal appeal.

A Coverage Denial means Our determination that a service, treatment, drug or device is specifically limited or excluded under this Certificate.

The internal appeals process may be initiated by the Member, the Member's authorized representative, or a Provider acting on behalf of the Member within 60 days of receipt of Our written notice of a Coverage Denial, or any other adverse decision made by Us, but must be filed within six months of your receipt of the initial decision. The request should include any medical

information pertinent to the appeal. All portions of the medical records that are relevant to the appeal and any other comments, documents, records or other information submitted by the Member relating to the issue being appealed, regardless of whether such information was considered in making the initial decision, will be considered in the review of the appeal. Any new medical information pertinent to the appeal will also be considered. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal.

If a representative is seeking an appeal on behalf of a Member, We must obtain a signed Designation of Representation (DOR) form from the Member. The appeal process will not begin until Anthem has received the properly completed DOR. We will forward a Designation of Representation form to the Member for completion.

The individuals responsible for reviewing your request for an internal appeal will not be the same individuals who made the initial denial or determination. They will not be the subordinates of the initial decision-maker either and no deference will be given to the initial decision.

Within a reasonable period of time but no later than 30 days after receiving a written or an oral request for an appeal, We will send a written decision to the Member or their authorized representative.

Contact Person For Appeals

The request for an internal appeal must be submitted to the following address or telephone number or to the appeal address or telephone number provided on your written notice of an adverse decision:

Blue View Vision
ATTN: Appeals
555 Middle Creek Parkway
Colorado Springs, CO 80921

Telephone Number: 866-723-0515

The Plan encourages its Members to submit requests for appeal in writing. The request for appeal should describe the problem in detail. Attach copies of bills, medical records, or other appropriate documentation to support the appeal that may be in your possession.

You must file appeals on a timely basis. As state above, you are encouraged to file internal appeals within 60 days of your receipt of the Plan's initial decision. Internal appeals must be filed, however, within six months of your receipt of the initial decision.

Vision Services

We are not liable for the furnishing of Covered Services, but merely for the payment of them. You shall have no claim against Us for acts or omissions of any Provider from whom you receive Covered Services. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure before filing a lawsuit or other legal action of any kind against the Plan. If your vision benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

Indiana
Life and Health
Insurance
Guaranty
Association
Disclaimer

Notice Of Protection Provided By The Indiana Life And Health Insurance Guaranty Association

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

Annuities

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace Suite 100
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Notice:**The accompanying contract does not provide prepaid services or merchandise under Indiana Code 30-2-13.**

This life insurance policy and certificate does not entitle the policyholder, certificateholder or any other person to:

- prepaid services or merchandise in conjunction with the death, funeral, burial, or final disposition of the insured under IC 30-2-13; or
- the right to file a complaint with the Indiana State Board of Funeral and Cemetery Service established by IC 25-15-9-1 for restitution from the preneed consumer protection fund under IC 30-2-13-29;

unless ownership of the certificate is irrevocably assigned to a trustee to fund a contract entered into with a seller (as defined under IC 30-2-13-10) under IC 30-2-13.

This life insurance policy and certificate:

- is not guaranteed to be exempt as a resource in determining eligibility for Medicaid under IC 12-15-2-17; and
- does not guarantee Medicaid eligibility.

Medicaid eligibility determinations are made in accordance with applicable Medicaid laws and policies.



Underwritten by Anthem Insurance Companies, Inc.

Notice of Privacy Practices



Information That's Important to You

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits

Want to save more trees? Go to anthem.com and sign up to receive these types of notices by e-mail.

State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company - without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity. You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

HIPAA notice of privacy practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.

For health care operations: We use and share PHI for health care operations.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital.

Examples of ways we use your information for payment, treatment and health care operations:

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit <https://www.anthem.com/health-insurance/about-us/privacy> for more information.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice may also require your written OK. You always have the right to revoke any written OK you provide.

You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI for other types of activities including:

- Health oversight activities;
- Judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents);

- Organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety;
- Special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes; and
- As required by law.

If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI - unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use or disclose PHI that is an individual's genetic information for underwriting.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.
- Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to Anthem, Anthem does not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, Anthem does not have to agree to your restriction.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We have to keep your PHI private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law and outlined in this notice.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Contacting you

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment, or billing.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Effective Date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision date is indicated in the footer of this Notice.

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance. Contact your Plan administrator for more information.

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In most of Missouri: RightCHOICE[®] Managed Care, Inc. (RIT), Healthy Alliance[®] Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross and Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWi collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. [®] ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

