VISION BENEFIT BOOKLET

DIOCESE OF FORT WAYNE – SOUTH BEND INC.
Blue View Vision Plan
Effective 1/1/ 2015

Administered By

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

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

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

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

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

BENEFIT BOOKLET

This Benefit Booklet has been prepared by the Claims Administrator, on behalf of the Employer, to help explain Your dental benefits. This document replaces and supersedes any Benefit Booklet or summary that You have received previously.

Please refer to this Benefit Booklet whenever You require dental services. It describes how to access dental care, what health services are covered by the Plan, and what portion of the dental care costs You will be required to pay.

This Benefit Booklet should be read and re-read in its entirety. Since many of the provisions of this Benefit Booklet are interrelated, You should read the entire Benefit Booklet to get a full understanding of Your dental benefits.

Many words used in the Benefit Booklet 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 Vision Benefit Booklet also contains Exclusions, so please be sure to read this Dental Benefit Booklet carefully.

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

If You need assistance in Spanish to understand this document, You may request it for free by calling customer service at the number on Your Identification Card.

Administered by
Anthem Insurance Companies, Inc.

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SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the amount of benefits the Plan will pay 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 this Benefit Booklet including any attachments or riders.

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Materials and any items not covered below may be purchased at discount pricing from a Blue View Vision Provider. In addition, benefits are payable only for expenses incurred while the group and insured person's coverage is in force.

- The schedule below represents the Plan allowance toward eligible benefits and may not cover all charges.
- The next frequency of the eligible benefits are based upon last date of service.
- The lens option discount program is listed below for informational purposes only. It is subject to change without notice and is not included in the Plan.
- Insured members receive 20% off the balance over the Plan allowance for frames and 15% off the balance for conventional contact lenses.
- See the Definitions Section of this Benefit Booklet for definitions of elective and non-elective contact lenses.

BENEFIT PERIOD	Calendar Year
DEPENDENT CHILD AGE LIMIT	To the end of the month in which the child attains age 26.

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network Providers	**Non-Network Providers**
Exam (including dilation and refraction as needed) Limited to one exam per Member every 12-months[1]	$10 Copayment, then Covered in Full, up to the Maximum Allowable Amount	Reimbursed up to $35
Prescription Lenses Standard plastic lenses up to 55 mm; and all ranges of prescriptions Single Vision lenses (pair) Bifocal lenses (pair) Progressive lenses (pair) Trifocal lenses (pair) Lenticular lenses (pair) Limited to one pair of lenses per Member every 12-months[1]	$20 Copayment, then Covered in Full, up to the Maximum Allowable Amount	Reimbursed up to $25 Reimbursed up to $40 Reimbursed up to $40 Reimbursed up to $55 Reimbursed up to $80
Frames Limited to one set per Member every 24-months[1]	No Copayment; Reimbursed up to $120 retail value	Reimbursed up to $45
Prescription Contact Lenses (in lieu of frame and lens benefits) (traditional or disposable) **Elective Contact Lenses** Availability every 12-months[1]	No Copayment; Reimbursed up to $105 retail value *	Reimbursed up to $105*
The Contact Lens benefit is paid toward materials first; any remaining amount will be applied to professional fitting fees). Professional fitting fees are not a Covered Service, but may be covered or partially covered by applying any remaining contact lens allowance unused for the materials (lens) purchase. Any remaining amount will be applied to the fee of the prescribing Provider.		
Non-Elective Contact Lenses** Availability every 12-months[1]	No Copayment	Reimbursed up to $210*

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network Providers	**Non-Network Providers**
Lens Options	Member Cost for Upgrades	Discounts on lens option upgrades are not available out-of-network.
UV Coating	$15	
Tint (Solid & Gradient)	$15	
Standard Scratch-Resistance	$15	
Standard Polycarbonate	$40	
Standard Progressive (Add-on to Bifocal Copayment)	$65	
Standard Anti-Reflective Coating	$45	
Other Add-ons and Services	20% off retail	

- [1] from the last date the procedure was performed or service rendered.

- *This limit on contacts is the same for Network and Non-Network and includes contact lens professional fees.

- **Contact lenses are eligible following cataract surgery or for extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses.

DEFINITIONS

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

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

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

Administrative Services Agreement - The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the vision care benefits of the Employer's Group Health Plan.

Benefit Booklet - This summary of the terms of Your health benefits.

Benefit Period - The period of time that benefits for Covered Services are payable under the Plan. The Benefit Period is listed in the Schedule of Benefits. If Your coverage ends earlier, the Benefit Period ends at the same time.

Calendar Year – The period of time that benefits are tracked. The Member must wait until the calendar year interval of which they can receive Covered Services as listed in the Schedule of Benefits.

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

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

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

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

- Not specifically excluded or limited by the Benefit Booklet; and
- Specifically included as a benefit within the Benefit Booklet.

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

Dependent - A person of the Member's family who is eligible for coverage under the Plan.

Effective Date - The date Your coverage begins under the Plan. You must be Actively at Work on Your Effective Date. If You are not Actively at Work on Your Effective Date, Your Effective Date will be the date You become Actively at Work. A Dependent's coverage under the Plan begins on the Effective Date of the sponsoring Subscriber. No benefits are payable for services and supplies received before Your Effective Date or after Your termination date.

Elective Contact Lenses - All contact lenses that are not Non-Elective Contact Lenses.

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

Employer - The legal entity contracting with the Claims Administrator for administration of group health care benefits.

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

Family Coverage - Coverage for the Subscriber and eligible Dependents.

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

Identification Card - A card issued by the Claims Administrator, on behalf of the Employer, that bears the Member's name, identifies the membership by number, and may contain information about Your benefits under the Plan. It is important to carry this card with You.

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

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

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

Low Vision – Any severe visual problem that is not substantially correctable with regular lenses, including single lenses, bifocal lenses, trifocal lenses, and Lenticular lenses.

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

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

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

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

Member - A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Employer and for whom Fee payment has been made. Members are sometimes called "You" or "Your."

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

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:

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

Non-Network Provider - A Provider who has not entered into a contractual agreement with the Claims Administrator for the Network associated with this Plan. Providers who have not contracted or affiliated with the Claims Administrator's designated Subcontractor(s) for the services they perform under this Plan are also considered Non-Network Providers.

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

Plan – The group health benefit Plan provided by the Employer and explained in this Benefit Booklet.

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

Subscriber - An eligible employee or retired employee or member of the Employer enrolled under the Plan, whose benefits are in effect and whose name appears on the Identification Card issued by the Claims Administrator, on behalf of the Employer.

ELIGIBILITY, ENROLLMENT AND TERMINATION

Eligibility for Benefit

(1) Employee Eligibility – Each Employee is eligible to enroll provided such Employee meets all of the following Requirements:

a. is in an eligible class as shown below:

(i.) all active, full-time Employees defined as follows:

Lay Employees (Non Teaching) who consistently maintain active employment of at least 30 hours per week;

Lay Employee (Elementary School Teacher) – a person who is contracted to teach 30 or more hours per week for a consecutive period equivalent to at least one full semester during the school year; or

Lay Employee (High School Teacher) – a person who is contracted to teach an average of five classroom periods of recitation and assumes daily supervisory assignments for a consecutive period equivalent to at least one full semester during the school year.

b. has completed a service requirement referred to as a Waiting Period:

(i.) the first day of the month following full-time employment;

c. has completed an enrollment application.

Failure of the Employee to enroll in the 30 days following the end of the Waiting Period will result in the Employee having to wait until Open Enrollment (January 1) to make application for coverage unless the Employee qualifies for Special Enrollment.

(2) Dependent Eligibility – Each Employee that is enrolled can enroll Dependents under the Plan on the later of the following:

a. for initially eligible Dependents, the date of the Employee is eligible to enroll; or

b. for newly acquired Dependents, the date the Dependent is first acquired by the Employee if the Employee is enrolled on that date.

Failure to enroll initially eligible Dependents in the 30 days following the end of the Employee Waiting Period will result in the Dependent having to wait until Open Enrollment (January 1) to make application for coverage unless the Employee qualifies for Special Enrollment.

The event of acquiring a new Dependent means marriage, birth, adoption, placement for adoption or satisfying any other definitions of Dependency as described in this Plan.

The election to enroll a newly acquired Dependent can occur at any time not more than 30 days following the event of acquiring the Dependent. If the Employee has dependent coverage under this Plan and such Employee or spouse of the Employee gives birth, the newborn Dependent shall be enrolled in the Plan automatically as of the date of birth. Any other newly acquired Dependent must be enrolled in accordance with the terms of the Plan. Failure to enroll a newly acquired Dependent in the 30 days following the acquisition event will result in the Dependent having to wait until Open Enrollment (January 1) to make application for coverage unless the Dependent qualifies for Special Enrollment.

No person is eligible for coverage as an Employee and as a Dependent. If both parents of a child are covered Employees under the Plan, the child may be covered as a Dependent of only one parent.

(3) Dependents eligible to participate include:

a. coverage will be extended only to the opposite sex Spouse of the Employee. For information on spousal eligibility please contact the Employer; and

b. a natural child, a step child, a legally adopted child, a child placed for adoption, a child who has been placed under the legal guardianship of the Employee or a child for whom the Employee has financial responsibility for medical Expense as the result of a legal decree. To be eligible, a child also must meet all of the following conditions:

    (i) dependent children at the end of the month they attain age 26

NOTE: Under any circumstance, a Dependent child covered under the predecessor plan on the day prior to the effective date of this Plan shall be covered by this Plan as long as such child continues to satisfy criteria (i) of this Section (3) b.

The limiting age of 26 does not apply to an enrolled child who is mentally or physically handicapped at or prior to the time the child reaches the limiting age. Upon attaining the limiting age, the child must also be incapable of self-sustaining employment and chiefly dependent upon the Employee for support and maintenance. Proof of incapacity must be furnished to the Employer; additional proof may be requested from time to time.

ADOPTED CHILDREN: The Plan allows coverage of a child who has been adopted or placed for adoption. Placement for adoption means the assumption and retention by a Plan Participant of a legal obligation for total or partial support of such child in anticipation of such adoption.

Qualified Medical Child Support Order

(1) A Qualified Medical Child Support Order (QMCSO) is a court judgment or decree that requires the Plan to offer coverage to the child of a Participant, referred to as an alternate recipient.

(2) The medical child support order must meet four requirements to be deemed as qualified:

   a. disclose the name and last known mailing address of the Participant and each alternate recipient;
   b. reasonably describe the type of benefits or coverage to be provided by the Plan;
   c. define the period of time to which the order applies; and
   d. identify each Plan to which the order applies.

(3) The QMCSO cannot require the Plan to provide benefits not included under the Plan.

(4) Coverage of an alternate recipient is subject to all provisions of the Plan including, but not limited to, timely payment of required contributions, enrollment procedures and limitations of coverage.

(5) The Plan Administrator has established procedures for determining if a court judgment or decree is a QMCSO. A Participant can obtain a copy of these procedures without cost upon written request to the Plan Administrator.

Application For Participation

(1) Each Employee must apply for Plan participation on such forms or electronic format as the Employer shall provide and shall agree to the terms of the Plan. The Employer shall determine Participant eligibility based upon information supplied.

(2) The enrollment application shall include a statement which, upon signature or acceptance by the Employee, authorizes the Employer to make payroll withholding of any required contribution by the Employee for the cost of benefits. Such authorization is part of the application procedure.

(3) If a declination to enroll occurs due to other coverage of an Employee or Dependent, the Employee must state in writing that the reason for declination is due to other coverage. Failure to make the written statement will void the right to Special Enrollment at a future date.

(4) The Participant is solely responsible for the accuracy of information and to notify the Plan Administrator of any change in status that may have a material effect on eligibility or otherwise affect the capability of the Plan Administrator to fulfill the obligations of the Plan.

Effective Date of Coverage

(1) If completion of the enrollment application occurs prior to or during the 30 days immediately following the scheduled effective date, coverage begins on the scheduled effective date.

(2) The scheduled effective date is the first day of the month coincident with or next following the end of the service Waiting Period. The service Waiting Period begins on the first day of Actively At Work, full-time employment.

(3) If an Employee is not Actively at Work on the scheduled effective date except for health related causes and the effective date is a regularly scheduled work day, neither Employee nor Dependent coverage begins until the day the Employee returns to active, full-time employment.

(4) If the scheduled effective date falls on a non-work or vacation day, coverage begins on the scheduled effective date if the Employee was Actively at Work on the last preceding regularly scheduled work day or, if absent from work, such absence was due to health related causes. Otherwise, neither Employee nor Dependent coverage begins until the day the Employee returns to active, full-time employment.

(5) Upon completion of application requirements, the effective date of coverage for Dependents is described as follows:

a. for initially eligible Dependents, the date the Employee is effective;

b. for newly acquired Dependents, the date a Dependent is first acquired by the Employee if the Employee is covered on that date; or

(6) A terminated Employee, whose coverage has terminated, may reapply for coverage within twelve (12) months following such termination of employment without fulfilling the Waiting Period requirement.

Special Enrollment

(1) A Special Enrollment right exists for eligible Employees and Dependents who previously declined coverage under this Plan due to having other health coverage and subsequently loses such other coverage. To qualify for Special Enrollment, the Employee must:

a. state in writing at the time of initial eligibility that declination of coverage under this Plan was due to having other coverage;

b. make the request for Special Enrollment; and

c. complete any required Enrollment Forms under this Plan not more than 30 days following the loss of other coverage.

(2) A person who enrolls under the provisions for Special Enrollment is not subject to the Waiting Period.

(3) The Special Enrollment right requires:

a. If the other coverage is COBRA continuation, the Special Enrollment request is available only after exhausting the maximum eligible duration of COBRA coverage.

b. If the other coverage is not COBRA continuation, the Special Enrollment request is available only after losing eligibility for the other coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or after cessation of Employer contributions for the other coverage.

(4) The Special Enrollment right does not apply if the Participant loses other coverage as a result of failure to pay premiums or for cause, such as (but not limited to) making a fraudulent claim.

(5) The effective date of coverage under this Plan shall be:

a. if enrollment in this Plan occurs not more than 30 days following the loss of other coverage, the date of losing other coverage; or

b. if enrollment in this Plan occurs more than 30 days following the loss of other coverage, the date of enrollment in this Plan.

Dependent Special Enrollment

(1) A Dependent Special Enrollment right exists for Eligible Employees and Dependents upon the acquisition of a new Dependent through marriage, birth of a child, adoption of a child, or placement of a child for adoption. To qualify for the Dependent Special Enrollment right, the Employee must request the Dependent Special Enrollment and complete any required Enrollment Forms under this Plan not more than 30 days following the acquisition of a new Dependent.

(2) Eligible Employees and Spouses who previously declined coverage may also enroll under the Dependent Special Enrollment right, provided they are otherwise eligible.

(3) A person who enrolls under the provisions for Dependent Special Enrollment is not subject to the Waiting Period.

(4) The effective date of coverage under this Plan in the case of Dependent Special Enrollment shall be:

a. if enrollment in this Plan occurs not more than 30 days following the loss of other coverage, the date of losing other coverage; or

b. For a newborn or adopted child, coverage is retroactive to the date of birth or date of adoption.

Medicaid and CHIP Special Enrollment/Special Enrollees

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).

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Termination of Coverage

Coverage of an Employee or Dependent ends when the first of the following events takes place.

(1) the date the Plan ends;

(2) the date the Participant is no longer in an eligible class or satisfies the definitions of eligibility as stated in the Eligibility Provisions of this Plan;

(3) the date the Plan is changed to end benefits for the class to which the Participant belongs;

(4) the end of the period for which the Participant no longer satisfies the Contributory cost requirement established by the Employer; or

(5) the end of the month in which employment is terminated; or

(6) the day of the Plan Month in which the Participant requests such coverage be terminated.

The end of coverage will not affect any claim made for benefit while a Participant.

Family and Medical Leave (FMLA)

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

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

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

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

Please contact Your Human Resources Department for state specific Family and Medical Leave Act information.

Military Leave Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA)

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge. Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA-like continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

HOW TO OBTAIN COVERED SERVICES

Services and Benefits

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

The Plan may inform You that a service You received is not a Covered Service under the Benefit Booklet. You may appeal this decision. See the Complaint and Appeals procedures section of this Benefit Booklet.

Network Providers are Professional Providers and other facility Providers who contract with the Claims Administrator, on behalf of the Employer, 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

Non-Network Services and Benefits

Services that are not obtained from a Network Provider will be considered a Non-Network Service. Network Providers must be used to obtain benefits and Discounts.

Relationship of Parties (Plan - Network Providers)

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

The Claims Administrator or the Subcontractor 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 Network Provider or in any Network 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 the Claims Administrator or Your Provider.

Not Liable for Provider Acts or Omissions

The Claims Administrator and/or the Employer are not responsible for the actual care You receive from any person. This Benefit Booklet does not give anyone any claim, right, or cause of action against the Claims Administrator and/or the Employer based on what a Provider of vision care, services or supplies, does or does not do.

COVERED SERVICES

This section describes the Covered Services available under Your vision care benefits when provided and billed by eligible Providers. All Covered Services are subject to the exclusions listed in the Exclusions section and all other conditions and limitations of the Benefit Booklet. The amount payable for Covered Services varies depending on whether You receive Your care from a Network Provider or a 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:

- Vision examinations
- Lenses
- Frames
- Contacts Lenses in lieu of Frame and Lenses
- Low Vision Services

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 frame that is valued at more than the Maximum Allowable Amount You are responsible for the difference in cost.

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

Vision Eye Examination

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

- Case history
- Recording corrected and uncorrected visual acuity
- Internal exam
- External exam
- Pupillary reflexes
- Binocular vision
- Objective refraction
- Subjective refraction
- Glaucoma test
- Slit lamp exam (Biomicroscopy)

- Dilation
- Color vision
- Depth perception
- Diagnosis and treatment plan.

Eyeglass Lenses

Eyeglass lenses are available in standard or basic plastic (CR39) lenses including single vision, bifocal, and trifocal 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 anti-reflective coating or ultra-violet coating. These and any other lens add-ons may be discounted according to our Additional Savings Program.

Frames

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

Elective Contact Lenses

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

Fitting Fees

The Member is responsible for 100% of the fitting fee at the time of service. The Contact Lens allowance is paid toward materials first; any remaining amount will be applied to the professional fitting fee.

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.

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 (3) 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, the Plan's 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: The Plan will not reimburse for Non-Elective Contact Lenses for any Member who has undergone prior elective corneal surgery, such as Radial Keratotomy (RK), Photorefractive Keratectomy (PRK), or Lasik.

Low Vision Services

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

Eligibility

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

- The best corrected acuity is 20/200 or less in the better eye, or

- There can be demonstrated a constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point or the widest diameter subtends an angle less than 20 degrees in the better eye.

Low Vision Benefits

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

- Comprehensive Low Vision exam.

- Optical/non-optical aids.

- Supplemental testing.

Any supplemental testing is considered part of the optical/non-optical aids total maximum allowance.

Special Note: Supplemental testing includes, but is not limited to: Automated Visual Fields, Contrast Sensitivity testing, Glare testing, Color Vision testing, Visually Evoked Potential (VEP) testing, Electroretinogram (ERG) testing, and Electro-oculogram (EOG) testing.

Materials Options

Benefits are available for the services below in accordance with the Schedule of Benefits. The Member will be responsible for the following items when the charges exceed the Maximum Allowable Amount.

- Blended lenses;
- Contact lenses (except as noted herein);
- Oversize lenses;
- Progressive multifocal lenses;
- Photochromatic lenses, or tinted lenses other than Pink #1 or #2;
- Coated lenses;
- Frames that exceed the Maximum Allowable Amount;
- Low Vision (except as noted herein);
- Cosmetic Spectacle Lenses;
- Optional cosmetic items; and
- UV-protected lenses.

EXCLUSIONS

This section indicates items which are excluded 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. This list of Exclusions is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

The Plan does not provide vision benefits for services or supplies:

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

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

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

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

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

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

7. Received from a vision 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, or 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 Benefit Booklet.

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

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

16. For sunglasses and accompanying frames.

17. For safety glasses and accompanying frames.

18. For inpatient or outpatient hospital vision care.

19. For Orthotic or vision training and any associated supplemental testing.

20. For non-prescription lenses.

21. For two pairs of glasses in lieu of bifocals.

22. For Plano lenses (lenses that have no refractive power).

23. For medical or surgical treatment of the eyes.

24. Lost or broken lenses or frames, unless the Member has reached his or her normal interval for service when seeking replacements.

25. For services or supplies not specifically listed in the Benefit Booklet.

26. No Benefits are available for services that are not specifically described as Covered Services in this Benefit Booklet. This exclusion applies even if Your Physician orders the service.

27. Certain brands on which the manufacturer imposes a no discount policy.

28. For services or supplies combined with any other offer, coupon, or in-store advertisement.

29. For vision enhancements for Polycarb, Transition lenses and Scratch coating when provided by an Non-network Provider.

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 the Claims Administrator 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
P.O. Box 8504
Mason, OH 45040-7111

Assignment

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

Member Notice of Claim

This provision is applicable when the Member submits a claim. The Plan is not liable unless the Claims Administrator receives written notice that Covered Services have been given to You. An expense is considered incurred on the date the service or supply was given.

The notice must be given to the Claims Administrator by You within 90 days of receiving the Covered Services, and must have the data the Claims Administrator needs to determine benefits. Failure by You to give the Claims Administrator notice within 90 days will not reduce any benefit if You show that the notice was given as soon as reasonably possible. No notice can be submitted by You later than one year after the

usual 90 day filing period ends. If the notice submitted does not include sufficient data the Claims Administrator needs to process the claim, then the necessary data must be submitted to the Claims Administrator within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

Claim Forms

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

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

Member's Cooperation

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

Claims Review

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Explanation of Benefits

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

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by Your coverage;
- The amount for which You are responsible (if any);
- General information about Your Appeals rights and information regarding the right to bring an action after the Appeals process.

GENERAL PROVISIONS

Entire Agreement

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

Form or Content of Benefit Booklet

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

Circumstances Beyond the Control of the Plan

The Claims Administrator, on behalf of the Employer, shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Claims Administrator or Employer, 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 Claims Administrator, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided by the Plan is delayed or rendered impractical. In such event, the Claims Administrator and Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the Claims Administrator and Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

Coordination of Benefits

This Plan is considered primary in all circumstances.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under this Plan shall not duplicate any benefits to, which Members are entitled or for which they are eligible under any other governmental program. To the extent the Plan

has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Right of Recovery

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

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

Relationship of Parties (Employer-Member-Claims Administrator)

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

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

Transfer of Benefits

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

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

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

Conformity with Law

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

Modifications

This Benefit Booklet allows the Employer to make Plan coverage available to eligible Members. However, this Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Administrative Services Agreement, or by mutual agreement between the Employer and the Claims Administrator without the permission or involvement of any Member. Changes will not be made effective until the date specified in the written notice the Claims Administrator provides to the Employer about the change. By electing vision coverage under the Plan or accepting the Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Benefit Booklet.

Clerical Error

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

Policies and Procedures

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

Waiver

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

Plan's Sole Discretion

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

Reservation of Discretionary Authority

The Claims Administrator shall have all powers necessary or appropriate to enable it to carry out its duties in connection with the administration of the Plan and the interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement to determine all questions arising under the Plan, to resolve Member appeals and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. The Claims Administrator has complete discretion to interpret the Benefit Booklet. The Claims Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are covered. The Claims Administrator's decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable Member appeal procedures.

Anthem Insurance Companies, Inc. Note

The Employer, on behalf of itself and its participants, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between the Employer 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 Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Booklet.

YOUR RIGHT TO APPEAL

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

- Your coverage and benefit levels, including Reimbursement amounts;
- Specific claims or services You have received;

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

The Complaint Procedure

A Complaint Procedure is available to provide reasonable, informative responses to complaints that You may have concerning the Plan. A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Plan of its procedures and contracts. The Plan invites You to share any concerns that You may have over benefit determinations or coverage cancellations. If You have a complaint or problem concerning benefits or services, please contact the Claims Administrator. You may submit Your complaint by letter or by telephone call. Or, if You wish, You may meet with Your local service representative to discuss Your complaint.

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

The Appeals Procedure

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

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

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

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

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

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

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

Contact Person For Appeals

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

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

Telephone Number: 1-866-723-0515

The person holding the position named above will be responsible for processing Your request.

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

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

Vision Services

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

Limitation of Actions

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

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

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

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

For Payment: We use and share PHI to manage Your account or benefits; or to pay claims for health care You get through Your plan. For example, we keep information about Your premium and deductible payments. We may give information to a doctor's office to confirm Your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services You get. We may also use PHI to provide You with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as Your doctor or a hospital. But, we may share PHI with Your health care provider so that the provider may treat You.

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

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

As Allowed or Required by Law: We may also share Your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that You may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If You are enrolled with us through an employer sponsored group health plan, we may share PHI with Your group health plan. We and/or Your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

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

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 them 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. They can give You the address to send the request. They can also give You any forms we have that may help You with this process.

How we protect information

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

We keep Your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep Your PHI safe include offices that are kept secure, computers that need passwords,

and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The 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 non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without Your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

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

Complaints

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

Contact Information

Please call Customer Service at the phone number printed on Your ID Card. They 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.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

STATE NOTICE OF PRIVACY PRACTICES

As we told You in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains Your rights and our legal duties under state law.

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. PI could also be used to make judgments about Your health, finances, character, habits, hobbies, reputation, career, and credit.

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.

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.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.