

A Guide to Your Benefits

*You've made a good decision in choosing
Blue View Vision*

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BLUEVIEW SUMMARY OF VISION BENEFITS

Anthem West – Exam Only Plan

This Summary of Vision Benefits outlines the vision benefits available to you through the Anthem Vision Plan. This is a summary of your vision benefit. Please review your benefit certificate for plan details. For eligibility definitions please contact your group administrator.

Blue View Vision's Provider Network: Blue View Vision members have access to approximately 32,500 conveniently located providers nationwide. Blue View Vision contracts with many providers, which including independent optometrists and ophthalmologists as well as well as LensCraftersSM, Target Optical and most Sears Optical and Pearle Vision retail locations. Members may call Blue View Vision toll-free at (866) 723-0515 or visit www.anthem.com at any time for provider locations.

For fast, paperless determination and confirmation of benefits, simply schedule an appointment with your *Blue View Vision* Provider and identify yourself as a *Blue View Vision* member.

Network Provider: Maximum benefits are achieved when members access their benefits from a *Blue View Vision* Participating Provider. Copayment(s) may apply to in-network benefits.

Non-Network Provider Reimbursements: Members may go to a non-participating (non-network) provider and pay the provider directly for services and materials. Members must then submit an original itemized invoice and a copy of the prescription along with the Member's I.D. number to *Blue View Vision* for reimbursement according to the Non-Network Reimbursement schedule identified in this Summary of Vision Benefits.

Value Added Savings: *Blue View Vision* providers agree to the Additional Savings Plan that is significantly below retail. Members are able to achieve substantial savings on additional pair purchases, contact lenses, lens treatments, specialized lenses and various other items. Members may save approximately 15% to 40% off retail on these items when they visit a *Blue View Vision* Provider.

Copayment(s): Copayment amounts are applicable to Network Provider examinations. Plan allowances must be applied for a single service within a member's benefit year; no remaining balance may be carried forward for another service within the benefit year.

| BlueView Vision Benefits | Member Benefit from Network Provider | Non-Network Reimbursement |
|---|---|----------------------------------|
| Vision Examination: Each member is entitled to a comprehensive vision examination by a Network Provider. This is a vision examination only and does not cover a separate contact lens professional fitting fee. Availability : Once every 12 months* | HMO: \$15.00 Copayment Point-of-Service: \$20.00 Copayment BluePreferred: \$25 Copayment | Up to \$35.00 |
| Materials: Prescription lenses and frames | Available at Anthem Vision Preferred Prices | Not Covered |
| Contact Lenses: | Available at Anthem Vision Preferred Prices | Not Covered |

* Benefits are available from the last date of service

Limitations and Exclusions:

This is a primary vision care benefit and is intended to cover an eye examination only. Materials and any items not covered may be purchased at Preferred Pricing from an Anthem Vision Provider. In addition, the examination is only payable while the group and member coverage is in force.

- Eyeglass Frames
- Eyeglass Lenses
- Elective or Non-Elective Contact Lenses
- Orthoptics or vision training and any supplemental testing.
- Plano (non-prescription) lenses.
- Medical or surgical treatment of the eyes.
- An eye exam or corrective eyewear required by an employer as a condition of employment.
- Any injury or illness covered under Workers' Compensation or similar law, or which is work related.
- Sub-normal vision aids.
- Experimental or non-conventional treatments or devices.
- Safety eyewear.
- In conjunction with other offers or discounts.

Welcome

We are pleased to welcome you as a Member of an Anthem Blue Cross and Blue Shield **Group Vision Plan**. This Membership Certificate is a guide to your coverage. Keep it in a convenient place for quick reference.

This Certificate has been prepared by us to help explain your vision care coverage. Please refer to this Certificate whenever you require vision services. It describes how to access vision care and what vision services are covered by us. See your Blue View Vision Summary of Benefits to determine what portion of the vision costs you will be required to pay.

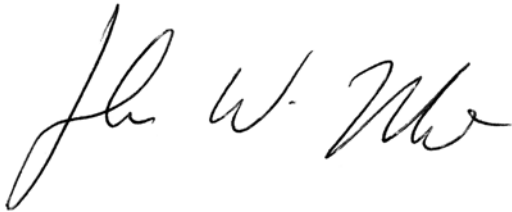
The coverage described in this Certificate is subject in every respect to the provisions of the Master Contract issued to the Group. The Master Contract and this Certificate and any amendments or riders attached to the same, shall constitute the Master Contract under which Covered Services and supplies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

This Certificate also contains **Exclusions**, so please read your Certificate carefully.

An additional benefit of your vision coverage is the backing of Anthem Blue Cross and Blue Shield.

A handwritten signature in black ink, appearing to read "John W. Martie". The signature is fluid and cursive, with a large initial "J" and "M".

John Martie
President and General Manager
Anthem Blue Cross and Blue Shield

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Introduction

This certificate is a summary of the provisions of the vision insurance provided for Anthem members insured under the Community Colleges plan.

This certificate also insures the subscriber's eligible dependents if they are covered under the health plan. All provisions of the health plan certificate are used to determine whether services are covered under this vision plan certificate.

Services and Benefits

If your care is rendered by a Network Provider, benefits will be provided at the Network level. Refer to the Health Benefit Plan Description Form. 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 it is not Medically Necessary for you to receive services. This decision is made upon review of your condition and treatment. We have final authority to determine the Medical Necessity of the service. You may appeal this decision. See Complaint Procedure in the How to File Claims in Appeals 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

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 Health Benefit Plan Description Form. You will be required to file claims for covered services 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 cost 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.

Definitions

This section defines certain words used throughout the Certificate. The first letter of each of these words will be capitalized whenever it is used as defined below in this text. Reading this section will help you understand the rest of the Certificate. You may also want to refer back to this section to find out exactly how — for the purposes of this Certificate — a word is used.

Anthem Blue Cross and Blue Shield (Plan) — Means Rocky Mountain Hospital and Medical Service, Inc., a Colorado insurance company doing business as Anthem Blue Cross and Blue Shield (also referred to as Anthem BCBS).

NOTE: “We,” “our,” and “us” refer to Anthem Blue Cross and Blue Shield or Anthem BCBS.

Benefit Year – Your Benefit Year begins on your effective date, and expires on the following June 30; a new Benefit Year commences on each subsequent July 1.

Certificate (Membership Certificate) — This document, which explains the benefits, limitations, exclusions, terms, and conditions of your health coverage.

Copayment - A specific dollar amount or percentage of the Maximum Allowable Amount for Covered Services indicated in the Health Benefit Plan Description Form for which you are responsible.

Covered Services - Services and supplies or treatment as described in the Certificate. To be considered Covered Services, services 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 or investigational or otherwise excluded or limited by the Certificate, or by any amendment or rider thereto.
- Authorized in advance by Anthem if such preauthorization is required in the Certificate.

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

Deductible - The dollar amount of Covered Services listed in the Health Benefit Plan Description Form for which you are responsible before we start to pay for Covered Services each Benefit Year.

Dependent — For dependent eligibility see Part 1 of your health certificate.

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 contact lenses that are not Medically Necessary Contact Lenses.

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

Family Coverage - A membership that covers two or more persons (the Subscriber and one or more Dependents).

Group - The employer that has entered into a Master Contract with the Plan.

Individual Membership — A membership covering one person (the Subscriber).

Master Contract — The agreement between us and your employer stating all of the terms and provisions applicable to your group coverage. The Master Contract governs the final interpretation of any specific provision contained in this Certificate.

Maximum Allowable Amount - The amount that we determine is the maximum amount payable for Covered Services you receive based on the established fee schedule. The Maximum Allowable Amount is subject to any Copayments, 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. We will reimburse up to the Non-Par Reimbursement schedule identified in the Summary Plan Description.

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.

Medically Necessary or Medical Necessity - Services or supplies received for the treatment of an illness or injury or other health condition that is determined by us to be:

- Appropriate and consistent with the diagnosis or symptoms, and consistent with accepted standards of practice;
- Not experimental/investigative or unproven;
- Not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment; and
- Not provided only as a convenience to you, your physician, or another Provider or person.

The fact that any particular Provider may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment Medically Necessary. We have the final authority for determining the Medical Necessity of Covered Services.

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, or with another organization which has an agreement with us, to provide Covered Services and certain administration functions for the Network associated with this Certificate.

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

Ophthalmology —a branch of medical science dealing with the structure, function, and diseases of the eye. An ophthalmologist must be licensed to practice ophthalmology.

Optometry — an examination of the eye for defects or faults in refraction and the prescribing of correctional lenses or exercises. An optometrist must be licensed to practice optometry.

Premium - The periodic charges which 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, which are required by applicable state law to be covered when rendered by such Provider.

Subcontractor - Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. 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 employee or member of the Group who is eligible to receive benefits under the Master Contract.

Membership Eligibility, Enrollment, Changes, and Termination

For eligibility information see Part 1 of your health certificate.

When Coverage Under This Vision Certificate Ends

If your group is covered by provisions requiring continuation of group coverage under Colorado or Federal Law (Consolidated Omnibus Budget Reconciliation Act of 1985 COBRA), you and your covered Dependents who lose eligibility under a group may be able to continue as group Members for a limited period of time. Contact your group for information. **Note: COBRA does not apply for vision if the group or member is not enrolled in a health coverage through Anthem Blue Cross and Blue Shield.**

If you are voluntarily removing a Dependent, the deletion will be effective the next service date following receipt of the membership change form.

If a Member does not elect or does not qualify for Colorado or COBRA continuation, coverage under this Certificate ends on the earliest of the following dates:

For any Member, including Dependents:

- When the Subscriber's employer gives us written notice of termination. If the employer fails to timely remove an ineligible Member, we reserve the right to recoup any benefit Payments made on behalf of such person. Coverage will be terminated on the next monthly service date.
- Upon the Subscriber's death.

NOTE: Surviving eligible Dependents remain covered through the last paid billing period. Surviving Dependents have the right to select Colorado or COBRA continuation coverage for himself/herself.

- When we do not receive the premium payment on time.
- When there is fraud or intentional misrepresentation of material fact on the part of the Member.
- When Medicare becomes the Member's primary coverage unless the Member is in a group with fewer than 20 employees. See **Medicare Eligible Members** in this section for additional information.
- When the Member is no longer eligible for this group coverage under the terms of the Master Contract.
- The date group coverage under this Certificate is discontinued for the entire group, or the employee's enrollment classification.

For a Dependent:

- When the Dependent child marries, such a dependent has the right to select Colorado or COBRA continuation.
- At the end of the last paid billing period for Dependent coverage.
- When the Dependent no longer qualifies as a Dependent by definition, such a dependent has the right to select Colorado or COBRA continuation.
- The date of a final divorce decree or legal separation for a Dependent spouse, such a dependent has the right to select Colorado or COBRA continuation.
- When the Subscriber notifies us in writing to end coverage for a Dependent.

We will not refund membership premium paid in advance on behalf of the deleted Member if:

- We do not receive the membership change form within 31 days of the effective date of change.
- We have paid any claims on behalf of the deleted Member.

Colorado or COBRA continuation coverage ends:

- When the Member becomes eligible or covered for all medical conditions under another group plan (as an employee or otherwise).
- **18, 29 or 36 months** after termination of coverage.
- The date on which an employee whose COBRA coverage was extended to 29 months is determined under the Social Security Act to no longer be disabled.
- When the Colorado or COBRA continuation period expires.

Grace Period

The Master Contract has a 60-day Grace Period. This means that if any required Premium is not paid in full, on or before the date it is due, it may be paid during the following 31 days without interest charge. During such Period, the Master Contract stays in force.

Reinstatement

If coverage under this Certificate lapses because the Premium has not been paid within the time allowed, you will not be reinstated automatically. Re-application may be necessary, unless termination resulted from inadvertent clerical error. 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.

Conversion

Conversion coverage is not available under this Certificate.

What We Will Pay For — Benefits

This section describes the Covered Services available under your vision care benefits when provided and billed by Network 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 Health Benefit Plan Description Form.

The following are Covered Services:

- Vision examination when performed by an ophthalmologist or optometrist.

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

What We Will Not Pay For — General Limitations and 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 benefits of services or supplies.

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

- Received from an individual or entity that is not a Provider, as defined in this Certificate.
- Which are experimental or investigative or related to such, whether incurred prior to, in connection with, or subsequent to the experimental or investigative service or supply, as determined by us.
- 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 benefits or compensation from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For illness or injury that occurs as a result of any act of war, declared or undeclared.
- For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- For which you have no legal obligation to pay in the absence of this or like coverage.
- 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.
- Prescribed, ordered, or referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except, as specified elsewhere in this Certificate or as otherwise prohibited by federal law.
- In excess of Maximum Allowable Amount.
- Incurred prior to your Effective Date.
- Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a Group, mutual benefit association, labor union, trust, or similar person or group (unless received by a Network provider).
- For 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, 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

- For sunglasses and accompanying frames.
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care.
- For orthoptics or vision training and any associated supplemental testing.
- For non-prescription lenses.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the Member has reached his or her normal interval for service when seeking replacements.
- For services or supplies not specifically listed in the Certificate.
- Low Vision
- Cosmetic Options
 - Blended lenses
 - Contact lenses (except as noted herein)
 - Oversize lenses
 - Progressive multifocal lenses
 - Photochromatic lenses or tinted lenses
 - Frames that exceed the Maximum Allowable Amount
 - Cosmetic lenses
 - Optional cosmetic processes
 - UV-protected lenses

GENERAL PROVISIONS

Administration

Note: 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 have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of this Certificate. This includes, without limitation, the power to construe the Contract and Certificate, to determine all questions arising under this Certificate, and to make, establish and amend the rules and 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 a reasonable relationship to the provisions of the Contract and Certificate. A specific limitation or Exclusion will override more general benefit language.

Anthem Insurance Companies, Inc.

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. (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Colorado. 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 this agreement.

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.

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.

Conformity with State Law

Any provision of this Plan, which is in conflict with the laws of the state in which it is issued, is hereby amended to conform with the minimum requirements of such laws.

Coordination of Benefits

We consider this Plan primary in all circumstances.

Disclaimer of Liability

We have no control over any diagnosis, treatment, care, or other service provided to a Member by any Provider, and we are not liable for any loss or injury caused by any health care Provider by reason of negligence or otherwise.

Entire Contract

This Certificate, the Master 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.

Execution of Papers

On behalf of yourself and your Dependents you must, upon request, execute and deliver to us any documents and papers necessary to carry out the provisions of this Certificate.

Form or Content of Certificate

No agent or employee of the Plan or anyone acting on our behalf 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.

Interpretation of Certificate

The laws and regulations of the State of Colorado, which issued the Certificate of Authority to the Plan, shall be applied to the interpretations of this Certificate.

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 Master Contract, or by mutual agreement between the Plan and the Group without the consent or concurrence of any Member. By electing vision 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.

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.

Payment in Error

If we make an erroneous benefit Payment, we may require you, the Provider of services, or the ineligible person to refund the amount paid in error. We reserve the right to correct Payments made in error by offsetting the amount Paid in error against new claims. We also reserve the right to take legal action to correct Payments made in error.

Pilot Programs

We may occasionally develop pilot programs to test different benefits or recognize different Providers. The fact that a pilot program may exist does not guarantee that all Members are eligible for pilot program benefits or that such benefits will be permanent.

Plan's Sole Discretion

The Plan or anyone acting on our behalf, may, at its sole discretion, cover services and supplies not specifically covered by the Certificate. 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.

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.

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.

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. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

Sending Notices

All notices to the Subscriber are considered to be sent to and received by the Subscriber when deposited in the United States mail with postage prepaid and addressed to either:

- The Subscriber at the latest address appearing on our membership records; or
- The Subscriber's employer.

Subscriber's Legal Expense Obligations

You and your Dependents are liable for any actions that may prejudice our rights under this Certificate. If we must take legal action to uphold our rights and prevail in that action, we will be entitled to receive and you agree to pay our legal expenses, including attorney's fees and court costs.

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.

How To File Claims and Appeals

This section explains how to file claims to obtain benefits, and what to do if you disagree with the action taken on your claim.

How to File Claims

When a Network Provider bills us for Covered Services, we will pay them the appropriate benefit directly. Payment is subject to any applicable Copayment requirements.

If a Non-Network Provider does not bill us directly, you must file your own claim. You must send us your receipt from the Provider and include your member number. Balance due statements, cash register receipts, and cancelled checks are not acceptable. All information on the receipt must be readable. If information is missing on your receipt or is not readable, it will be returned to you.

We are not required to honor an assignment of benefits to Non-Network Providers. We may honor an assignment of benefits to Non-Network Providers at our sole discretion. If we pay you directly, you will be responsible for paying the Non-Network Provider of services for all charges.

Where and When to Send Your Claim

Make copies of the bills for your own records and attach the original bills to the receipt. Submit the receipt (including your member number) to:

Anthem Blue Cross and Blue Shield
555 Middle Creek Parkway
Colorado Springs, Colorado 80921

Your claim must be filed **within 365 days** after the date of service. Any claims filed after this limit may be refused. Failure to file a claim within such time shall not invalidate or reduce any claim if it is shown that it was not reasonably possible to give such notice and that notice was given as soon as reasonably possible.

Your claim will be processed in accordance with the time frame as required by State law for prompt payment of claims.

Confidentiality and Disclosure of Information

This policy sets forth guidelines regarding a member's right to access and amend information in Anthem's possession. The policy specifically addresses when a release, signed by a Member, is required before information may be disclosed by us to parties such as a Member's Provider, spouse or other family Members. The policy includes the following key points:

- On the enrollment application, Subscribers sign a consent form to allow the release of any information or records concerning claims, conditions, or treatments of you, your Spouse, and/or your Dependents enrolled under the Plan for routine uses. Routine uses of Member information include but are not limited to: payment of claims, health care operations, plan administration, quality improvement, utilization review, Coordination of Benefits, audits, health promotion, disease management and prevention programs and other uses stated specifically in the enrollment application. By signing the application form, you also agreed and consented to the recording and/or monitoring of any telephone conversation between you and us.
- Members have the right to approve the release of information for non-routine uses of data. In certain circumstances, We may obtain a specific release form before information is disclosed.
- For members unable to give consent, We will obtain a copy of the guardianship papers or power of attorney before releasing confidential information to the Member's representative.

- Members have the right to access their medical records and to request that We restrict others access to their confidential information.
- We take reasonable precautions to protect Member information and maintain privacy in all settings. Our contracts with practitioners and providers explicitly state expectations about the confidentiality of Member information and records.
- We may provide certain information, upon request, to employers or their representatives without specific consent. In certain circumstances, We may request that you sign a specific release form before information is disclosed. If information is released, We advise the employer that it must be kept confidential to the extent necessary or as otherwise provided by law, and that it should not be used for unlawful purposes.

Also note that any person or entity having information about an illness or injury for which benefits are claimed may give us or anyone acting on our behalf any information about the illness or injury. We may provide any person or entity any information about an illness or injury upon its request, if it is providing similar benefits. Benefits will not be provided where sufficient information cannot be obtained to properly process a claim. You waive any and all privileges with respect to such information.

Our Customer Service Area may release information to you or your Spouse concerning a claim for benefits, or your coverage under this Certificate. If you do NOT want the Plan to release such information to anyone but yourself, you must notify us in writing. Your Spouse or any Dependent child over age 18 must also notify us in writing if they do not wish such information regarding their claims or coverage released to you by Customer Service.

The Member agrees to sign any papers and to provide Anthem Blue Cross and Blue Shield with any documents, papers, and information Anthem Blue Cross and Blue Shield may require to determine your rights under this Certificate and to determine the benefits on your claims.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Plan's business activities.

- The Plan or anyone acting on our behalf may collect personal information about a Member from persons or entities other than the Member.
- The Plan or anyone acting on our behalf may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances.
- A Member has a right of access and correction with respect to all personal information collected by the Plan or anyone acting on our behalf.
- The Plan or anyone acting on our behalf takes reasonable precautions to protect Member information in its possession, including the use of restricted computer access.
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Complaints

If you have a **complaint** about any aspect of our service or claims processing, please contact a Customer Service Representative at Anthem Blue Cross and Blue Shield at the phone number listed on your identification card. For purposes of this document, a **grievance** is a complaint about the quality of care or service received from a provider. You may also send a written complaint to the following address:

Anthem Blue Cross and Blue Shield
Customer Service Department

555 Middle Creek Parkway
Colorado Springs, CO 80921

A trained representative will work to clear up any confusion and resolve your difficulties. Your written grievance will be investigated by our Quality Management Department. If you are not satisfied with the decision of Anthem Blue Cross and Blue Shield Customer Service, you may file an appeal as explained below.

Appeals

Your appeal must be submitted in writing. While We encourage you to file appeals within 60 days of the adverse benefit determination, your written appeal must be received by Us within 180 days of the adverse benefit determination. Appeals may be for pre-service denials or post-service denials. We will assign a customer advocate to assist you in the appeal process. You must send written appeals to the following address:

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

An appeal may be filed with or without first submitting a complaint. In the appeal, you must state plainly the reason(s) why the claim or requested service or supply should not have been denied. You should include any documents not originally submitted with the claim or request for the service or supply and any information that may have a bearing on our decision.

For a thorough, unbiased review, you may access two internal levels of appeal. In the case of a benefit denial based on utilization review, an independent external review appeal is also available to you. For pre-service denials based on utilization review, an expedited appeal and expedited independent external review may be available in certain circumstances.

You may designate a representative (e.g., your Physician or anyone else of your choosing) to file any level of appeal review with us on your behalf. You must give this designation to us in writing.

The Appeals process is governed by laws and regulations, and may be modified from time to time by Us as those laws may require. A more detailed description of the Appeals process and the decision timeframes is set forth in our appeals guide. This guide is available through our website or may be obtained free of charge by calling customer service.

Legal Action

Before you take legal action on a claim decision:

- You must first follow the appeal process outlined above in **Complaints** and **Appeals**.
- You must meet all the requirements of this Membership Certificate.
- No action in law or in equity shall be brought to recover on this Certificate prior to expiration of 60 calendar days after written proof of loss has been filed in accordance with the requirements of this Certificate. No such action shall be brought at all unless brought within three years of the time within which written proof of loss has been filed as required by the Certificate.