

Welcome

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

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

The coverage described in this Benefits Booklet is subject in every respect to the provisions of the Plan Document and Summary Plan Description for the University of Colorado Health and Welfare Plan ("Plan Document"). We, or someone acting on our behalf, will generally determine how benefits will be administered and who is eligible for participation in a manner consistent with the terms of this Benefits Booklet. If any question arises about the interpretation of any provision of this Benefits Booklet, Our determination will be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/Investigational, or cosmetic. However, you may utilize all applicable Complaint, Grievance and Appeal procedures available under this Benefits Booklet.

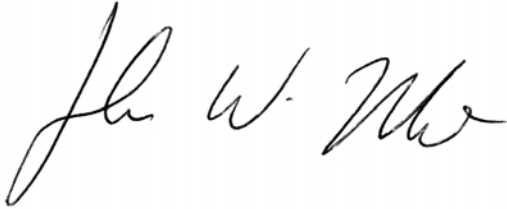
The Plan Document and any amendments or riders attached to the same shall constitute the Plan under which Covered Services and supplies are provided.

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

Many words used in the Benefits 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 Benefits Booklet also contains **Exclusions**, so please read your Benefits Booklet carefully.

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



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

Important: This is not an insured benefit Plan. *The benefits described in this Benefits Booklet or any rider or amendments hereto are funded by the employers and the subscribers. The benefits are paid from the Trust. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.*

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1. Introduction

Services and Benefits

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

Network Services

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 which 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 Summary of Benefits. You may be required to file claims for covered services you obtain directly from a Non-Network Provider.

Relationship of Parties (Network Providers)

The relationship between Anthem Blue Cross and Blue Shield and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of Anthem Blue Cross and Blue Shield, nor is Anthem Blue Cross and Blue Shield, or any employee of Anthem Blue Cross and Blue Shield, 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 us or your Provider.

Not Liable for Provider Acts or Omissions

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

2. Definitions

This section defines certain words used throughout the Benefits Booklet. 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 Benefits Booklet. You may also want to refer back to this section to find out exactly how — for the purposes of this Benefits Booklet — a word is used.

Administrative Services Agreement — the agreement among Anthem Blue Cross and Blue Shield, the Trust Committee, on behalf of the Trust, and the Plan Sponsor, regardless of how such an agreement may be titled, stating all the terms and provisions applicable to the administration of this Plan.

Anthem Blue Cross and Blue Shield (Plan Administrator) — 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.

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

Benefit Year — The Benefit Year is a plan year: from July 1 through June 30. The initial Benefit Year is from a member's effective date through the following June 30. If your coverage ends earlier, the benefit year ends at the same time.

Copayment - A specific dollar amount or percentage of the Maximum Allowable Amount for Covered Services indicated in the Summary of Benefits for which you are responsible.

Covered Services - Services and supplies or treatment as described in this Benefits Booklet. To be considered Covered Services, services must be:

- Specifically included as a benefit under this Benefits Booklet;
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Benefits Booklet is in force;
- Not otherwise excluded or limited by the Benefits Booklet or by any amendment or rider thereto.
- Authorized in advance by Anthem if such preauthorization is required in the Benefits Booklet.

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

Effective Date - The date when your coverage begins under this Benefits Booklet. A Dependent's coverage begins on the Effective Date of the sponsoring Subscriber or qualifying event.

Eligible Person - A person who satisfies the Plan'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 employers whose employees are covered by the Plan.

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

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 Benefits 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 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. We will reimburse up to the Non-Network Provider Reimbursement schedule identified in the Summary of Benefits.

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

Member - A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan Administrator; 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 Benefits Booklet.

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

Plan — the health benefit Plan provided by the Plan Sponsor and explained in this Benefits Booklet.

Plan Document — the Plan Document and Summary Plan Description for the University of Colorado Health and Welfare Plan, and the documents incorporated therein by reference.

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 special category retiree who is eligible to receive benefits under this Benefits Booklet.

3. 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 **General Limitations and Exclusions** section and all other conditions and limitations of this Benefits 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 Summary of Benefits.

The following are Covered Services:

- Vision examination

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

4. 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 Benefits Booklet.
- 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 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 Benefits Booklet 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 Benefits Booklet.
- 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 Administrator may, in its sole discretion, waive this exclusion in whole or in part for a specific new FDA approved drug product or technology.
- 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 this Benefits Booklet.
- 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, for all plans including full service plans.

5. General Provisions

Administration

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

The Plan Administrator, 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 Benefits Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement and this Benefits Booklet, to determine all questions arising under this Benefits Booklet, and to make, establish and amend the rules and regulations and procedures with regard to the interpretation and administration of the provisions of this Benefits Booklet. However, these powers shall be exercised in such a manner that has a reasonable relationship to the provisions of the Administrative Services Agreement and this Benefits Booklet. A specific limitation or exclusion will override more general benefit language.

Anthem Insurance Companies, Inc.

The Trust, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Benefits Booklet constitutes a contract solely among the Trust, the Plan Sponsor 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 Benefits Booklet.

Circumstances Beyond the Control of the Plan Administrator

In the event of circumstances not within the control of the Plan Administrator, 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 Administrator, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of vision care services provided under this Benefits Booklet is delayed or rendered impractical, the Plan Administrator shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan Administrator and Network Providers shall render services provided under this Benefits Booklet insofar as practical, and according to their best judgment; but the Plan Administrator 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 Administrator, 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 Benefits Booklet which is in conflict with the laws of the state in which it is issued is hereby amended to conform to the minimum requirements of such laws.

Coordination of Benefits

We consider this Benefits Booklet 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 Benefits Booklet, the Administrative Services Agreement, the Trust, the Plan Document, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire agreement among the Trust, the Plan Sponsor and Anthem and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan Administrator by the Trust Committee, on behalf of the Trust, and any and all statements made to the Trust Committee, on behalf of the Trust, by the Plan Administrator are representations and not warranties, and no such statement, unless it is contained in this Benefits Booklet, shall be used in defense to a claim under this Benefits Booklet.

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 Benefits Booklet.

Form or Content of Benefits Booklet

No agent or employee of the Plan Administrator or anyone acting on our behalf is authorized to change the form or content of this Benefits Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Plan Administrator.

Interpretation of Benefits Booklet

The laws and regulations of the State of Colorado shall be applied to the interpretations of this Benefits Booklet.

Modifications

By this Benefits Booklet, the Trust Committee, on behalf of the Trust, makes the Plan coverage available to eligible Members. However, this Benefits Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Administrative Services Agreement, or by mutual agreement among the Plan Administrator, the Trust Committee, on behalf of the Trust, and the Plan Sponsor, 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 Benefits Booklet 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 erroneously authorize a benefit Payment, we may require you, the Provider of services, or the ineligible person to refund the amount paid in error to the Trust. 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 Administrator's Sole Discretion

The Plan Administrator or anyone acting on our behalf, may, at its sole discretion, cover services and supplies not specifically covered by the Benefits Booklet. 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 Administrator may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Benefits Booklet with which a Member shall comply.

Relationship of Parties (Trust-Member-Plan)

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

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

Right of Recovery

Whenever payment has been made in error, we will have the right, on behalf of the Trust, 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.

Subscriber's Legal Expense Obligations

You and your Dependents are liable for any actions which may prejudice our rights or the rights of the Trust under this Benefits Booklet. If we must take legal action, on behalf of the Trust, to uphold our rights or the rights of the Trust and prevail in that action, we will be entitled to receive, on behalf of the Trust, 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 Administrator, has authority to waive any conditions or restrictions of this Benefits Booklet, to extend the time for making a payment to the Plan Administrator, or to bind the Plan Administrator by making any promise or representation or by giving or receiving any information.

6. How to File Claims and Appeals

This section explains how to file claims in order 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 authorize payment directly from the Trust to them of the appropriate benefit. 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.

Anthem Blue Cross and Blue Shield authorizes payment of the benefits under this Benefits Booklet directly to Network Providers. A list of Network Providers is available upon request. We authorize payment the benefits under this Benefits Booklet directly to Non-Network Providers, if you have authorized assignment of benefits, in writing. These payments fulfill the obligation of Anthem Blue Cross and Blue Shield to you for these services.

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
P.O Box 173690
Denver, Colorado 80217-3690

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 of your claim 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.

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 Vision
Customer Service Department
P.O Box 8504
Mason, OH 45040-7111

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 Anthem Blue Cross and Blue Shield encourages you to file appeals within 60 days of the adverse benefit determination, your written appeal must be received by Anthem Blue Cross and Blue Shield within 180 days of the adverse benefit determination. Appeals may be for pre-service denials or post-service denials. Anthem Blue Cross and Blue Shield 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, additional appeal rights are also available to you, including independent external review.

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 Anthem Blue Cross and Blue Shield as those laws may require. A more detailed description of the Appeals process and the decision timeframes is set forth in our appeals guide.

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 Benefits Booklet.
- No action in law or in equity shall be brought to recover on this Benefits Booklet prior to expiration of 60 calendar days after written proof of loss has been filed in accordance with the requirements of this Benefits Booklet. 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 Benefits Booklet.