

A Guide to Your Benefits

*You've made a good decision in choosing
The Blue View Vision Plan for the University of Colorado*

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BlueView Vision For the University of Colorado



This Summary of Vision Benefits outlines the vision benefits available to you through the Blue View Vision Plan. This is a summary of your vision benefit. Please review your benefit booklet 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 include independent optometrists and ophthalmologists 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/universityofcolorado 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 purchases of additional pairs of glasses, 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.

Blue View Vision Benefits	Member Benefit From Network Provider	Non-Network Reimbursement
<p>Vision Examination: Covered up to a comprehensive level exam with dilation as necessary from Network Provider.</p> <p>Availability : Once every 12 months*</p>	\$30 Copayment	Up to \$35

***From your last date of service**

Limitations and Exclusions

This is a primary vision care benefit and is intended to cover only eye examinations. Materials and other items not covered may be purchased through the Additional Savings Plan from a *Blue View Vision* Provider. In addition, benefits are payable only for expenses incurred while the Group and individual Member coverage is in force.

These plan benefits cannot be combined with any other discounts, promotional offers or advertised specials including, but not limited to, discounts, coupons or two-for-one materials offers, offered by the providers at their individual offices. Members must choose between using their benefits or the provider's special offers.

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Si usted necesita ayuda en español para entender este documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

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.

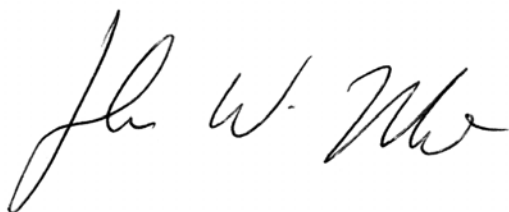
The Plan Document and any amendments or riders attached to the same shall constitute the Plan under which Covered Services and supplies are provided.

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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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.

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, Regent Board member, or special category retiree who is eligible to receive benefits under this Benefits Booklet.

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.

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.

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.

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

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial; and
- you are entitled to a full and fair review of the denial.

The procedure the Administrator will follow will satisfy the minimum requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, the Administrator's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Administrator's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA (if applicable) if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- the Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- the Administrator may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Administrator's decision, can be sent between the Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Administrator at the phone number listed on your Health Benefit ID card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

Upon request, the Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

The Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on appeal based on a new or additional rationale, the Administrator will provide you, free of charge, with the rationale.

How Your Appeal will be Decided

When the Administrator considers your appeal, the Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal

If you appeal a post-service claim, the Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Administrator will include all of the information set forth in the above subsection entitled "Notice of Adverse Benefit Determination."

Voluntary Second Level Appeals

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Administrator within four (4) months of the notice of your final internal adverse determination.

A request for a External Review must be in writing unless the Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Administrator's decision, can be sent between the Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Administrator at the phone number listed on your Health Benefit ID card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA (if applicable).

Requirement to file an Appeal before filing a lawsuit

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 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 but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan.

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

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.