Blue View Vision

anthem.com

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

Anthem BlueCross BlueShield

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VISION CERTIFICATE

Underwritten by Anthem Blue Cross and Blue Shield

Anthem

Vision Certificate of Coverage

(herein called the "Certificate")

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

Translation: If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number on the back of your id card or in your Certificate of Coverage.

Blue View Vision

Anthem Health Plans, Inc. d/b/a
Anthem Blue Cross and Blue Shield
108 Leigus Road
Wallingford, CT 06492

BLUE VIEW VISION
Customer Service
1-866-723-0515
www.anthem.com

CERTIFICATE

Welcome to Anthem! 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, what vision services are covered by us, and 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 Group Contract issued to the Group. The Group Contract and this Certificate and any amendments or riders attached to the same, shall constitute the Group Contract under which Covered Services and supplies are provided by us.

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

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

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

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

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

No prior authorization is required to receive covered vision services.

Benefit Period	Calendar Year
Dependent Age Limit	To the end of the month after which the child attains 26.

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network Providers	**Non-Network Providers**
Exam		
Limited to one exam per Member every Calendar Year.	$10 Copayment	Reimbursed up to $48
Prescription Lenses		
Standard: (including factory scratch coating, polycarbonate lenses for children under 19 years old and Photochromic lenses for children under 19 years old)		
Basic Lenses (Pair)		
Single Vision lenses	$10 Copayment	Reimbursed up to $36
Bifocal lenses	$10 Copayment	Reimbursed up to $54
Trifocal lenses	$10 Copayment	Reimbursed up to $69
(Limited to one set of lenses per Calendar Year.)		

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network Providers	Non-Network Providers
Frame		
(Limited to one frame per 2 Calendar Years)	$130 Retail Amount	Reimbursed up to $64
Prescription Contact Lenses (traditional or disposable)		
Non-Elective Contact Lenses (Availability once every Calendar Year)	Covered in Full	Reimbursed up to $210
Elective Contact Lenses (in lieu of eyeglass lenses allowances) (Availability once every Calendar Year)	$130 Retail Amount	Reimbursed up to $105
Note: If you elect covered Non-Elective Contact Lenses or Elective Contact Lenses within one calendar year period, no benefits will be available for covered lenses and frames until the next calendar year period.		
Laser Vision Correction Services		
Participating Lasik/photorefractive keratectomy PRK surgical centers offer a discounted rate for Members enrolled under this plan. You are responsible for any remaining charges.		

DEFINITIONS

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

"You" or "your" refers to the Eligible Person or the Dependent of the Eligible Person. The Eligible Person is the person for whom the Group has provided coverage through his or her employment. A Dependent is a covered Member of the Eligible Person. The Group has contracted with us to provide coverage for its group Members and their Dependents. "We," "us," and "our" refer to Anthem Health Plans. Other terms are defined in the "Definitions" section of the Certificate.

ADDITIONAL SAVINGS PROGRAM – A discount program included in the vision benefit program. It can be used for certain non-covered services and plan overages. The discount plan is subject to change at any time.

CALENDAR YEAR – The period of time that benefits are tracked. The Members must wait until the calendar year interval of which they can received Covered Services as listed in the Schedule of Benefits.

BENEFIT ALLOWANCE - The benefit available for covered services rendered by a Network Provider. The Benefit Allowances are identified in the Schedule of Benefits and are incurred by a Member in a Benefit Period. Member is responsible for Provider's Charges in excess of the Benefit Allowance.

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

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

COPAYMENT - A specific dollar amount or percentage of the Maximum Allowable Amount for Covered Services indicated in the Schedule of Benefits 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:

- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Certificate is in force;
- Within the Maximum Allowable Amount;
- Not specifically excluded or limited by the Certificate;
- Specifically included as a benefit within the Certificate.

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

CREDITABLE COVERAGE – (PROOF OF PRIOR COVERAGE) - The term Creditable Coverage means health coverage provided through an individual policy, a self-funded or fully insured group health plan offered by a public or private employer, Medicare, Medical Assistance, General Assistance Medical Care, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Federal Employees health Benefit Plan (FEHBP), Medical Care Program of the Indian Health Service of a tribal organization, a state health benefit risk pool, a State Children's Health Insurance Program (S-CHIPS), a qualified Public health Plan or a Peace Corp health plan.

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

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

ELECTIVE CONTACT LENSES - All contact lenses that are cosmetic in nature or not Non-Elective Contact Lenses.

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

FAMILY COVERAGE - Coverage for the Subscriber and eligible Dependents.

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

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

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

MAXIMUM ALLOWABLE AMOUNT - 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 amount indicated in the non-network reimbursement schedule indicated in the schedule 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; 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-ELECTIVE CONTACT LENSES - To be considered Non-Elective, lenses that are provided for reasons that are not cosmetic in nature. Non-Elective Contact lenses are typically prescribed when any of the following conditions have been identified/diagnosed: an unusual cone-shaped thinning of the cornea of the eye, which usually occurs before the age of 20 years and is referred to as Keratoconus; or when unusually high levels of near-sightedness, far-sightedness, or astigmatism are identified also referred to as High Ametropia; where one eye requires a much different prescription than the other eye also known as Anisometropia; or for reason that significantly improve vision clarity better than the best spectacle lens correction.

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.

PLAN - The term Plan means any Plan which provides benefits or services for Hospital, medical/surgical, or other health care diagnosis or treatment on a group basis. Examples of group Plans include but are not limited to: group or fraternal blanket insurance; group practice; individual practice; other Blue Cross and/or Blue Shield Plans; labor-management trustee Plan; union welfare Plan; employer organization Plan; employee benefit organization Plan.

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

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

Provider's Charge – The charge for services or items as shown on the provider's bill.

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 Group Contract.

ELIGIBILITY AND ENROLLMENT

Eligibility and Enrollment

To be eligible to enroll as a Subscriber you must be an employee of the Group who is entitled to participate in the benefit plan arranged by the Group, and meet the eligibility criteria stated in the Group Contract.

Persons who are eligible to enroll as Members must enroll at the time agreed upon by the Plan. Otherwise, they may only enroll during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

Eligible Dependents are your legal spouse and unmarried Dependent children who have not reached the age limits shown in the Schedule of Benefits.

If a Dependent of the Eligible Person qualifies as a Dependent under the Plan at the time of the Eligible Person's initial application for enrollment, but does not enroll, that person can only enroll for coverage during the open enrollment period or during a special enrollment period, which ever is applicable.

If a Subscriber wants to add a newly eligible Dependent due to marriage, birth, adoption, award of legal custody or guardianship, or loss of group vision coverage, the Subscriber must apply for coverage for that person even if enrolled for Family Coverage. That family member must be enrolled within 31 days of the event: birth, adoption, or placement for adoption, marriage, or other qualifying event.

Eligibility will be continued past the age limit only for a disabled Dependent child who is incapable of sustaining employment by reason of physical or mental handicap, provided:

a. The unmarried disabled Dependent child of the Eligible Person or his or her spouse is over the age limit set forth in the Certificate; and
b. The child is incapable of sustaining employment by reason of physical or mental handicap as certified by a Physician and for whom the Eligible Person or his or her spouse is chiefly responsible for support and maintenance; and
c. The child became disabled prior to the limiting age for a Dependent child and he or she had comparable coverage as a Dependent at the time of enrollment.

Proof acceptable to Anthem BCBS of such incapacity and dependency must be received within 120 days of the date upon which the child's coverage would have terminated in the absence of such incapacity. We may require continued proof of such disability annually after the two year period following this child's attainment of the limiting age.

Coverage Effective Dates and enrollment requirements are described in the Group Contract. For information on your specific Effective Date of coverage under this Certificate, you should see your Human Resources or benefits department or contact us.

If you return from full-time active service following a call to active military duty, no waiting period applies. You and eligible family members can reenroll in the Plan, provided you apply for reemployment within the time period permitted by the Uniformed Services Employment and Reemployment Act. The time period allowed for reemployment depends on the length of your active military duty. To reenroll in the Plan, your application must be received within 31 days of your reemployment date. Coverage will be effective on the effective date of your reemployment.

Employees returning from the military service must reenroll in the Plan within 31 days from the reemployment date. Coverage will be effective upon the date of your reemployment.

Special Enrollment

An Eligible Person or Dependent who was previously eligible for coverage, but did not enroll during an initial enrollment period, may be allowed to enroll during a Special Enrollment period. To be eligible for Special Enrollment the Eligible Person or Dependent must have declined coverage initially due to other vision coverage or the person becomes a Dependent of a Subscriber through marriage, birth, adoption or placement for adoption.

A Dependent of a Subscriber may enroll during the Special Enrollment period if the Dependent lost their other coverage and the Subscriber is currently enrolled in this Plan. In addition, both the Eligible Person and a Dependent can enroll together if either the Eligible Person or the Dependent loses other coverage.

Enrollment must be requested no later than 31 days after the date the coverage described above terminated or the date the person becomes a Dependent of the Subscriber

If we receive an application to add a Subscriber's Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, that person is only eligible for coverage during an open enrollment period. Application forms are available from the Plan.

Notice of Eligibility Changes

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

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

A Member's coverage terminates on the date such Member ceases to be in a class of Members eligible for coverage. The Plan has the right to bill the Subscriber for the cost of any services

provided to such person during the period such person was not eligible under the Subscriber's coverage.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Plan applications, or other forms or statements the Plan may reasonably request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Plan is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Certificate are subject to the condition that all such information is true, correct and complete. During the first two years following the effective date of the policy, any material misrepresentation by a Member may result in termination of coverage as provided in the Termination section.

TERMINATION, CONTINUATION AND CONVERSION

Termination

Termination is effective 15 days after the notice of termination is mailed.

This Certificate of Coverage is issued under a Group Contract. Termination of the Group Contract automatically terminates all your coverage as of the date of termination. It is the responsibility of the Group to notify you of the termination of the coverage. However, coverage will be terminated, regardless of whether the notice is given.

Except as otherwise provided, your coverage will terminate as follows:

- If you cease to meet eligibility requirements as outlined in this Certificate, your coverage will terminate. The Group and/or you shall notify us immediately if you cease to meet the eligibility requirements. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

- We may rescind the Plan or a Member's coverage during the first two (2) years for false, misleading or fraudulent information furnished to Us by the Group or a Member during the application or enrollment process. You shall be responsible to pay us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services. We will also terminate your Dependent's coverage; effective on the date your coverage was terminated. We will notify the Group in the event we terminate your and your Dependent's coverage.

- If you stop being a Subscriber or do not pay the required contribution, coverage terminates for all Members at the end of the period for which payment was made.

- A Dependent's coverage terminates on the date that person no longer meets the definition of Dependent.

- If coverage is through an association, coverage terminates the date Membership in the association ends.

Grace Period

The Group Contract has a 31 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 Group Contract stays in force.

If any required payment on your behalf is not made by the Group within the Grace Period, your rights shall terminate as of the last date for which Premiums have been made. Coverage may be reinstated only by renewed application and re-enrollment in accordance with all requirements of this Certificate. The Plan shall not be liable for any health care services incurred by any Member beyond the period for which the Premium shall have been paid. The Plan shall be entitled to indemnification by either the Group or the Member for any expense paid by the Plan under such circumstances.

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.

Federal Continuation of Coverage (COBRA)

You may continue this coverage if your current coverage ends because of any of the following qualifying events. You must be covered under this Benefit Program before the qualifying event in order to continue coverage. In all cases, continuation ends if the group contract terminates or required charges are not paid when due.

Qualifying Event	Who May Continue	Maximum Continuation Period
Employment ends, retirement, leave of absence, or reduction in hours (except gross misconduct dismissal)	Group Member and Dependent Members	Earliest of: 18 months, or Enrollment Date in other group coverage or Medicare, or Date Coverage would otherwise end.
Divorce or Legal Separation	Former spouse and child Dependent Members.	Earliest of: 36 months, or Enrollment Date in other group coverage or Medicare, or Date Coverage would otherwise end.

Death of Group Member	Surviving spouse and child Dependent Members.	Earliest of: 36 months, or Enrollment Date in other group coverage or Medicare, or Date Coverage would otherwise end.
Child Dependent Member loses eligibility	Child Dependent Member.	Earliest of: 36 months, or Enrollment Date in other group coverage or Medicare, or Date Coverage would otherwise end.
Total Disability of Group Member	Group Member and Dependent Members	Earliest of: 29 months after the Group Member leaves employment, or Date total disability ends, or Enrollment Date in other Group coverage or Medicare, or Date Coverage would otherwise end.
Retirees of Group Contractholder filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and Dependent Members	Lifetime Continuation
Employee leaves for duty in the military service	Group Member and Dependent Members	The 24 months continuation beginning on the first date of your absence from work; or The day after the date on which you fail to apply for or return to a position of employment
Surviving Dependent Members of a retiree on lifetime continuation due to bankruptcy of Group Contractholder	Surviving spouse and child Dependent Members.	36 months following retiree's death.

Continuation Options

Continuation options will be provided under each of the following circumstances for the period indicated or until the Member becomes eligible for other group insurance, except as otherwise stated in this Section.

Connecticut Continuation Rights, C.G.S. Section 38a-538 and 38a-554

a. As provided by Connecticut law, (Connecticut Continuation Rights, C.G.S. Section 38a-538 and 38a-554) the Policyholder shall allow a Member and his or her Dependents who become ineligible for continued participation under this Policy to elect to continue coverage as described below.

   - Upon termination of the Member's employment, other than as a result of death or the gross misconduct of the Member, the Member and his or her Dependent may continue coverage until the end of 18 months following the day on which he or she ceased to be eligible for coverage under this Policy;

   - Upon the Member's death, his or her Dependent may continue coverage until the end of 36 months following the day on which they ceased to be eligible for coverage under this Policy;

   - Upon dissolution of the Member's marriage, his or her Dependent may continue coverage until the end of 36 months following the day on which they ceased to be eligible for coverage under this Policy.

b. Upon the Member's absence from employment due to illness or injury, a Member and his or her Dependents may continue during the course of such illness or injury or for up to 12 months from the beginning of such absence.

c. Upon termination of the Policy by the Policyholder or Anthem BCBS, benefits for Covered Services for a Member who was Totally Disabled on the date of termination shall be continued without premium payment during the continuance of such disability for a period of 12 months following the month in which the Policy was terminated, provided the claim is submitted within one year of termination of the Policy.

d. An additional 11 months shall be available to a Member and an enrolled Dependent who is; determined to be disabled under Title II or Title XVI of the Social Security Act at the time he or she becomes eligible for extended continuation of coverage under Connecticut Continuation Rights, or becomes disabled at any time during the first 60 days of Connecticut Continuation Rights coverage. The Member or enrolled Dependent must provide notice of the disability determination to Anthem BCBS not later than 60 days after the date of the Social Security Administration's determination, and before the end of the initial 18 months of Connecticut Continuation Rights coverage.

e. A Member is required to provide timely notice to the Policyholder of his or her election to continue coverage. Except as provided in (c) above, a Member who continues coverage may be required to remit the applicable premium payment to the Policyholder. Payment of such premiums need not be made on behalf of the Member by the Policyholder if they are not received by the Policyholder on a timely basis. Failure of the Member to remit such premium may result in termination.

Continuation of Coverage Due To Military Service

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

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

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Benefit Program and upon payment of any required contribution of health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active employee contribution, if any, for continuation of health coverage. If continuation is elected under this provision, the maximum period of health coverage under this Benefit Program shall be the lesser of:

- The 24 months beginning on the first date of you absence from work; or
- The day after the date on which you fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under this Benefit Program.

Who May Elect to Continue Coverage?

Qualified Beneficiaries are eligible to elect to continue coverage. Qualified beneficiaries are individuals who had coverage under the Benefit Program immediately prior to the qualifying event and are either covered employees, spouses or Dependent Children of covered employees. A qualified beneficiary also includes a child born to or placed for adoption with the covered employee during the continuation period.

Choosing Continuation

Upon notice of the qualifying event, the Group Contractholder must notify the Group Member of the option to continue coverage within 10 days.

You must choose to continue coverage by notifying the Group Contractholder in writing. You have 60 days to elect to continue coverage, starting with the date of the notice of continuation or

the date coverage is terminated, whichever is later. Your failure to choose continuation within the required time period will make you ineligible to choose continuation at a later date.

Paying for Continuation Coverage

You have 45 days from the date of electing continuation to pay the first continuation charges. After this initial grace period, you must pay charges monthly in advance to the Employer Group to maintain coverage in force. Failure to remit continuation charges within 30 days of the due date will result in termination of coverage. Charges for continuation are the group rate plus a 2% administrative fee. If the Group Member's total disability was the qualifying event for continuation, the cost to continue coverage could be the group rate plus a 2% administrative fee.

Social Security Determination for Total Disability

If the Covered Person or the Dependent Member is Totally Disabled at the time the Group Member leaves employment, or becomes disabled within the first 60 days of continuation of coverage, an additional 11 months shall be available to the Group Member and enrolled Dependents. In order to qualify for this extension, the individual must be determined to be disabled under Title II or Title XVI of the Social Security Act at the time he or she becomes eligible for extended continuation of coverage under continuation, or becomes disabled at any time during the first 60 days of continuation coverage. The Covered Person or enrolled Dependent must provide notice of the disability determination to Anthem BCBS not later than 60 days after the date of the Social Security Administration's determination, and before the end of the initial 18 months of continuation coverage.

If it is determined that the Member is no longer disabled, the extended continuation of coverage period can be terminated on the first of the month following 30 days after the final determination notice.

Special Continuation Rights for Totally Disabled Members When Group Contract Terminates

Upon termination of the Benefit Program by the Employer Group or Anthem BCBS, benefits for Covered Services for a Member who was Totally Disabled on the date of termination shall be continued for up to 12 months without Premium payment. The claim must be submitted within 12 months of the termination of the Benefit Program.

MEMBER APPEAL PROCESS

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

* Your coverage and benefit levels, including Reimbursement amounts;
* Specific claims or services you have received.

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

The Complaint Procedure

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

If you have a complaint or problem concerning benefits or services, please contact Us. You may submit your complaint by letter or by telephone call. Or, if you wish, you may meet with your local service representative to discuss your complaint.

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

The Appeals Procedure

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

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

The internal appeals process may be initiated by the Member, the Member's authorized representative, or a Provider acting on behalf of the Member within 60 days of receipt of Our written notice of a Coverage Denial, or any other adverse decision made by Us, but must be filed within six months of your receipt of the initial decision. The request should include any medical information pertinent to the appeal. All portions of the medical records that are relevant to the appeal and any other comments, documents, records or other information submitted by the Member relating to the issue being appealed, regardless of whether such information was

considered in making the initial decision, will be considered in the review of the appeal. Any new medical information pertinent to the appeal will also be considered. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal.

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

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

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

Contact Person For Appeals

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

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

Telephone Number: 866-723-0515

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

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

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

HOW TO OBTAIN COVERED SERVICES

Network Services and Benefits

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

We may inform you that a service you received is not a Covered Service under the Certificate. You may appeal this decision. See the Member Appeal Process section of this Certificate.

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

Non-Network Services and Benefits

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

Relationship of Parties (Plan - Network Providers)

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

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Provider or in any Provider's facilities.

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

COVERED SERVICES

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

Payment amounts are specified in the Schedule of Benefits.

The following are Covered Services:

- Routine Vision examinations
- Standard Eyeglass Lenses
- Frames
- Contact Lenses in lieu of Eyeglass Lenses

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

If you choose a frame that is valued at more than the Maximum Allowable Amount you are responsible for the difference in cost.

Vision Eye Examination

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

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

- Diagnosis and treatment plan.

Eyeglass Lenses

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

Frames

The frame allowance is based upon the retail cost. The Member may apply the plan allowance toward the provider's selection of frames. The Schedule of Benefits list the frame allowance available under your plan. If you choose a frame that is valued at more than the Maximum Allowable Amount you are responsible for the balance based upon the Additional Savings Program.

Elective Contact Lenses

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

Fitting Fees

A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Non-Elective Contact Lenses

This benefit is available for a limited number of diagnoses and is in lieu of the standard contact lens or lenses & frame benefit.

Eligibility

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

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

SPECIAL NOTE: We will not reimburse for Non-Elective Contact Lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Cosmetic Options

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

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

EXCLUSIONS

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

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

- 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, aliment, 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 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.
- In excess of amount allowed by the Plan.
- 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.
- 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 or plano lenses.
- For two pairs of glasses in lieu of bifocals.
- 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 fitting or dispensing fees for glasses and frames.
- For services or supplies not specifically listed in the Certificate.
- For no plan coverage/reimbursement will be made for non-elective contact lenses for members who have undergone cataract surgery or any elective corneal surgery, which includes but is not limited to RK, PRK, or Lasik.
- For services or supplies combined with any other offer, coupons or in-store advertisement.
- On discounts not available on certain frame brands in which the manufacturer imposes a no discount policy.

CLAIMS PAYMENT

Obtaining Services/Claim Payment

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

- The name, address and phone number of the Non-Network provider along with an itemized statement of charges
- The covered Member's name and address, group number, Social Security number or Member identification number
- The patient's name, birth date and relationship to the Member
- An Out-of-Network claim form obtained online at anthem.com or by calling customer service.

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

Blue View Vision
Attn: Claims Administration
PO Box 8504
Mason, Ohio 45040-7111

Assignment

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

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted to you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If a clean claim is not submitted to us, we will notify you or the Provider within 30 days after the date the claim was filed electronically or by paper and provide an explanation of any corrective actions needed.

At Our discretion, benefits will be paid to you or the Provider of services within 30 days after we have received the corrected information necessary to process your claim. You may not assign any payment. If other parties have paid benefits under this Plan, we may reimburse those other parties and be fully discharged from that portion of its liability.

Member's Cooperation

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

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. However, Our Explanation of Benefit forms will contain information on all claims for benefits under your coverage, and will be sent to the person in whose name the coverage is held (except as prohibited by law).

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.

GENERAL PROVISIONS

Entire Contract

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

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.

Circumstances Beyond the Control of the Plan

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

Coordination of Benefits

We consider this Plan primary in all circumstances.

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.

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.

Interpretation of Certificate

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

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.

Modifications

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

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.

Vision Examination

We, or anyone acting on Our behalf, has the right to have a Provider examine you as often as is reasonably required while we, or anyone acting on Our behalf, are processing a claim. You will be notified in advance.

Policies and Procedures

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

Waiver

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

Plan's Sole Discretion

The Plan 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.

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 Health Plans Note

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Certificate constitutes a contract solely between the Group and Anthem Health Plans (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Connecticut. 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.

Vision Services

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

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after we receive the claim or other request for benefits and within three years of Anthem'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.

DOMESTIC PARTNER COVERAGE RIDER

I. DEFINITION:

The definition of Domestic Partnership for this rider shall be two individuals, of the same or opposite sex, that live together in a long-term relationship of indefinite duration with an exclusive mutual commitment in which the Domestic Partners ("Partners (s)") agree to be jointly responsible for each other's common welfare and share financial obligations.

II. ELIGIBLE GROUPS

1. All employer groups that meet the eligibility requirements for group coverage of Anthem Blue Cross and Blue Shield (Anthem BCBS) may request Domestic Partner coverage.

2. The employer group's contribution schedule must remain neutral with respect to Domestic Partner coverage.

III. DOMESTIC PARTNER ELIGIBILITY CRITERIA

1. Domestic Partner eligibility between two persons of the same or opposite sex exist when all the requirements identified in A, B, C and D below are satisfied:

A.) Domestic Partners must meet all of the criteria below:

i. Each party is the sole Domestic Partner of the other.
ii. Each party is at least eighteen (18) years of age.
iii. Both parties currently share a common legal residence and have shared said residence for at least 12 months prior to application for Domestic Partner coverage.
iv. Domestic Partners must be jointly responsible for basic living expenses.
v. Both parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future.
vi. Neither party is married to another person.
vii. Neither party is related to the other by adoption or blood to a degree of closeness that would bar marriage in the state in which they reside, except for those states that legally recognizes Domestic Partners as a legal valid marriage.

B). Domestic Partners must have in effect and provide proof of any one of the following:

i. Designation of Domestic Partner as beneficiary for life insurance and retirement contract; or
ii. Designation of Domestic Partner as primary beneficiary in the (Member's) will; or,
iii. Documentation by one Partner designating the other partner as his/her agent for:

Personal relationship issues, or
Health care decisions, or
Health Care agent.

C). Neither party has filed a Termination of Domestic Partnership within the preceding 12 months.

D). To enroll an eligible Domestic Partner, both the Member and the Domestic Partner must complete and sign the Anthem BCBS Statement of Domestic Partnership. Signatures must be witnessed and notarized by a notary public. Anthem BCBS reserves the right to make the ultimate decision in determining eligibility of the Domestic Partner.

IV. DEPENDENT ELIGIBILITY

Dependent children of the Member and/or Partner are eligible for benefits for covered services if the following requirements are satisfied:

1. The child(ren) is/are primarily dependent upon the Member and/or Partner for support and a parent-child relationship exists between the Member and child(ren) based on all of the conditions as set forth in a, b, c and d below being met:

a) the child(ren) must be unmarried and reside in the same household as the Member and Partner, with the Member and Partners home as the primary place of residence.

b) the children must be within the age limits as stated in the Policy.

c) the Member and/or Partner must assume full parental responsibility and control, including any and all debts incurred by the child(ren) (i.e., charges for health care services and supplies)

d) The Member and/or Partner must be (1) a biological parent, or (ii) have a court appointed legal relationship with the child(ren) i.e. guardianship, adoption, foster child), or (iii) have been designated as the responsible party under a Qualified Medical Child Support Order (QMCSO).

*Dependency is determined in accordance with the applicable Internal Revenue Service guidelines.

1. In the case of a newborn infant of the Member and/or Partner or enrolled dependent, such child shall be eligible for benefits for covered services from birth through age 31 days under the policy of their parents(s), subject to any applicable managed care or managed benefits provisions of this Policy. An infant age 32 days or over who meets the criteria IV, (1), (a) through (d) is eligible for benefits for covered services as a dependent child.

2. In the case of a full time student if the Member and/or Partner, a full time student is eligible for coverage when he/she meets the criteria in IV, (1), (a) through (d) above; and is between the age limits as stated in the Policy and, is a full-time student at a recognized college, university, or trade school, is accredited by its corresponding trade of professional organization, or is approved by the State Department of Education or Public Health equivalent licensing department in other states.

3. In the case of an unmarried disabled dependent child of the Member and/or Partner, where "disabled" means that the child is incapable of sustaining employment by reason of physical or mental handicap, the disabled child may continue as dependent beyond the age limit set forth in this Policy provided:

   a) proof of disability is submitted and accepted by Anthem BCBS. Note: Anthem BCBS may require proof of disability annually.

   b) the child became disabled prior to the age limit for a dependent child set forth in the Policy under which the child was eligible for benefits for Covered Services, and

   c) the child had comparable coverage as a dependent at the time of application for eligibility for benefits for Covered Services under this Policy.

V. EFFECTIVE DATE OF COVERAGE

Coverage for Domestic Partners and eligible dependents of the Domestic Partner will be as follows:

1. Upon the firm's initial enrollment, provided all Domestic Partnership eligibility requirements are satisfied and approved by Anthem BCBS.

2. A newly hired Member may enroll a Partner provided all Domestic Partnership eligibility requirements are satisfied and approved by Anthem BCBS. The Effective Date of coverage will be in accordance with any applicable waiting period in place by the PolicyHolder and/or Anthem BCBS.

3. In the case where the PolicyHolder has an open enrollment period, an existing Member may enroll the Domestic Partner provided all Domestic Partnership eligibility requirements are satisfied and approved by Anthem BCBS. Eligibility for enrollment other than during the open enrollment period will be in compliance with Anthem BCBS Late Enrollee policy.

4. In the case where the PolicyHolder has no Open Enrollment Period, eligibility will be in compliance with Anthem BCBS Late Enrollee policy.

VI. TERMINATION

If the Domestic Partnership status changes such that the Partner is no longer eligible for coverage, the Member must complete and file a Termination of Domestic Partnership form within 30 days of the change of such status.

Once a Termination of Domestic Partnership has been submitted, the Member may not cover another partner for at least 12 months.

VII. CONTINUATION OF GROUP COVERAGE

Domestic Partners may each continue coverage under applicable State or Federal extension of coverage laws. The termination of the Domestic Partner status shall be considered for the purpose of this rider as a qualifying event to allow for the application of such continuation of benefits.

VIII. CONVERSION TO INDIVIDUAL COVERAGE

Upon termination of a Domestic Partnership, where the partner loses group health coverage, the Partner may apply for coverage through the Health Reinsurance Association (HRA).