

**LOS ANGELES CITY EMPLOYEES' RETIREMENT  
SYSTEM**

*January 1, 2021*

***Blue View Vision<sup>SM</sup> Plan***

## CERTIFICATE OF INSURANCE

Anthem Blue Cross Life and Health Insurance Company  
21215 Burbank Blvd.  
Woodland Hills, California 91367

This Certificate of Insurance, including any amendments and endorsements to it, is a summary of the important terms of your vision plan. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. The Group Policy, of which this certificate is a part, must be consulted to determine the exact terms and conditions of coverage. If you have special health care needs, you should read those sections of the Certificate of Insurance that apply to those needs. Your employer will provide you with a copy of the Group Policy upon request.

Your vision care coverage is insured by Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health). The following pages describe your vision care benefits and includes the limitations and all other *policy* provisions which apply to you. The *insured person* is referred to as "you" or "your," and Anthem Blue Cross Life and Health as "we," "us" or "our." All italicized words have specific *policy* definitions. These definitions can be found in the DEFINITIONS section of this certificate.

**Important Notice:** This is an important document and should be kept in a safe place. Sign your name in the space below when you receive this booklet.

---

Signature of Employee

## **COMPLAINT NOTICE**

**Should you have any complaints or questions regarding your coverage, and this certificate was delivered by a broker, you should first contact the broker. You may also contact us at:**

**Anthem Blue Cross Life and Health Insurance Company  
Member Services  
21215 Burbank Blvd.  
Woodland Hills, CA 91367  
818-234-2700**

**If the problem is not resolved, you may also contact the California Department of Insurance at:**

**California Department of Insurance  
Claims Service Bureau, 11th Floor  
300 South Spring Street  
Los Angeles, California 90013**

**1-800-927-HELP (4357) – In California**

**1-213-897-8921 – Out of California**

**1-800-482-4833 – Telecommunication Device for the Deaf**

**E-mail Inquiry: “Consumer Services” link at  
[www.insurance.ca.gov](http://www.insurance.ca.gov)**



## TABLE OF CONTENTS

<b>TYPES OF PROVIDERS .....</b>	<b>1</b>
<b>SUMMARY OF BENEFITS.....</b>	<b>2</b>
VISION CARE BENEFITS .....	2
GENERAL INFORMATION.....	4
<b>YOUR VISION CARE BENEFITS.....</b>	<b>5</b>
HOW COVERED VISION EXPENSE IS DETERMINED.....	5
VISION CARE CO-PAYMENTS AND BENEFIT MAXIMUMS.....	5
HOW TO USE YOUR VISION CARE BENEFITS.....	5
CONDITIONS OF COVERAGE .....	6
VISION CARE THAT IS COVERED .....	7
VISION CARE THAT IS NOT COVERED.....	8
<b>HOW COVERAGE BEGINS AND ENDS .....</b>	<b>10</b>
HOW COVERAGE BEGINS .....	10
HOW COVERAGE ENDS .....	15
<b>CONTINUATION OF COVERAGE.....</b>	<b>17</b>
<b>GENERAL PROVISIONS .....</b>	<b>23</b>
<b>BINDING ARBITRATION .....</b>	<b>26</b>
<b>DEFINITIONS.....</b>	<b>27</b>



## TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS VISION CARE MAY BE OBTAINED. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS BOOKLET ENTITLED DEFINITIONS.

**Participating Vision Care Providers.** Anthem Blue Cross Life and Health has contracted with various *vision care providers* to provide a network of "Participating Vision Care Providers." These providers are called "participating" because they have agreed to participate in our participating provider program (PPO), which we call Blue View Vision. They have agreed to provide *insured persons* with vision care at a negotiated fee. The amount of benefits payable under this *plan* will be different for *non-participating vision care providers* than for *participating vision care providers*.

To find a *participating vision care provider*, you may call us at the member services number listed on your ID card or you may also search for a *participating vision care provider* using the "Provider Finder" function on our website at [www.anthem.com/ca](http://www.anthem.com/ca).

**Non-Participating Vision Care Providers.** *Non-participating vision care providers* are providers which have not agreed to participate in our network. They have not agreed to the *negotiated rates* and other provisions. You will be responsible for any amounts they charge in excess of our payment.

## SUMMARY OF BENEFITS

THE BENEFITS OF THIS CERTIFICATE ARE PROVIDED ONLY FOR SERVICES WHICH ARE SPECIFIED IN THIS CERTIFICATE AS COVERED SERVICES. THE FACT THAT YOUR VISION CARE PROVIDER PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT A COVERED SERVICE OR A COVERED VISION EXPENSE.

This summary provides a brief outline of your benefits. You need to refer to the entire certificate for complete information about the benefits, conditions, limitations and exclusions of your *plan*.

### VISION CARE BENEFITS

Your vision care benefits cover eye examinations and eyewear only. You can choose to have your eyewear services provided by *participating vision care providers* or by *non-participating vision care providers*; however, your benefits will be affected by this choice.

### CO-PAYMENTS

#### Participating Vision Care Provider Co-Payments

- Comprehensive vision exam ..... **\$20**
- Lenses ..... **No co-payment\***
- Frames..... **No co-payment**
- Contact lenses ..... **No co-payment**

\* If you select progressive lenses, there will be an additional **\$30** co-payment.

**Note:** In addition to the Co-Payment shown above, you will be required to pay any amount in excess of the vision care benefit maximums for vision care services. But, when you go to a *participating vision care provider*, your cost for vision care services and supplies in excess of the benefit maximum will be at discount prices.

**Non-Participating Vision Care Provider Co-Payments.** There will be no co-payment required for services and supplies provided by a *non-*



*participating vision care provider*, but, you will be responsible for any billed charge which exceeds the Vision Care Benefit Maximum.

**VISION CARE BENEFIT MAXIMUMS**

We will pay benefits, for the following services and materials, up to the maximum dollar amounts and benefit periods shown below:

**Participating Vision Care Provider**

- Comprehensive vision exam ..... one exam  
per 12-month period\*
- Frames..... **\$150.00**  
one frame per 24-month period\*
- Prescription lenses ..... one pair  
per 12-month period\*
  - Single vision lenses..... **Covered in full**
  - Bi-focal lenses..... **Covered in full**
  - Progressive lenses..... **Covered in full\*\*\***
  - Tri-focal lenses..... **Covered in full**
  - Lenticular lenses ..... **Covered in full**
- Non-elective contact lenses..... **Covered in full**  
once per 12-month period\*
- Elective contact lenses\*\* ..... **\$120.00**  
once per 12-month period\*
- Low Vision ..... **\$1,000.00**  
per 24-month period\*

\* From the last date of service.

\*\* Contact lenses are in lieu of eyeglass lenses. If you choose elective contact lenses in a benefit period, we will not pay benefits for eyeglass lenses during that same benefit period.

\*\*\* If you select standard progressive lenses, there will be an additional **\$30** co-payment.

**Non-Participating Vision Care Provider**

- Comprehensive vision exam ..... **\$49.00**  
one exam per 12-month period\*
- Frames..... **\$70.00**  
one frame per 24-month period\*
- Prescription lenses ..... one pair  
per 12-month period\*
  - Single vision lenses..... **\$45.00**
  - Bi-focal lenses..... **\$65.00**
  - Progressive lenses..... **\$85.00**
  - Tri-focal lenses..... **\$85.00**
  - Lenticular lenses ..... **\$125.00**
- Non-elective contact lenses..... **\$210.00**  
once per 12-month period\*
- Elective contact lenses\*\* ..... **\$105.00**  
once per 12-month period\*

\* From the last date of service.

\*\* Contact lenses are in lieu of eyeglass lenses. If you choose elective contact lenses in a benefit period, we will not pay benefits for eyeglass lenses during that same benefit period.

**GENERAL INFORMATION**

**Contributions**—The insurance for you and your *family members* is *contributory insurance*. You will be informed of the amount of your contribution when you enroll.

**Anthem Blue Cross Life and Health’s Address—**

Anthem Blue Cross Life and Health Insurance Company  
Group Services  
P.O. Box 70000  
Van Nuys, California 91470

## **YOUR VISION CARE BENEFITS**

### **HOW COVERED VISION EXPENSE IS DETERMINED**

*Covered vision expense* is based on a maximum charge for each covered service or materials which we will accept. It is not necessarily the amount a vision care provider bills for the service. Expense is incurred on the date you receive the service or materials for which the charge is made.

**Participating Vision Care Providers.** The maximum *covered vision expense* for services provided by a *participating vision care provider* will be the lesser of the billed charge or the *negotiated rate*. *Participating vision care providers* have agreed not to charge you more than the *negotiated rate* for covered services.

If you choose frames or lenses that cost more than the Vision Care Benefit Maximum, you will pay the excess at a discounted price. If you choose vision options that are not covered under this *plan*, you will be charged a discounted price.

**Non-Participating Vision Care Providers.** The maximum *covered vision expense* for services provided by a *non-participating vision care provider* will always be the lesser of the billed charge or the Vision Care Benefit Maximum shown in the SUMMARY OF BENEFITS. You will be responsible for any billed charge which exceeds the Vision Care Benefit Maximum.

**You will always be responsible for expense incurred which is not covered under this *plan*.**

### **VISION CARE CO-PAYMENTS AND BENEFIT MAXIMUMS**

After we subtract your Co-Payment, we will pay benefits up to the amount of *covered vision expense*, not to exceed the applicable Vision Care Benefit Maximum. The Co-Payments and Vision Care Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

### **HOW TO USE YOUR VISION CARE BENEFITS**

**When You Go to a Participating Vision Care Provider.** To identify you as an insured covered for vision care benefits, you will be issued an identification card. You must present this card to *participating vision care providers* when you go for your appointment. A *participating vision care provider* will only charge your Co-Payment and any charges in excess of the Vision Care Benefit Maximum. When a *participating vision care provider* bills us for covered services, we will pay them directly.

**When You Go to a Non-Participating Vision Care Provider.** If you go to a *non-participating vision care provider* for services, you will have to pay the full cost of the eye examination and/or for any lenses you purchase. You should make copies of the bills for your own records and attach the original bills to the receipt. Send us the receipt with your ID number, at the address below:

**Anthem Blue Cross Life and Health Insurance Company  
Blue View Vision  
P.O. Box 8504  
Mason, OH 45040-7111**

You must send us your receipt from the *vision care provider* with your ID number within 90 days of the date of exam and/or purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

#### **CONDITIONS OF COVERAGE**

The following conditions of coverage must be met for expense incurred for services or supplies to be considered as *covered vision expense*.

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or materials for which the charge is made.
2. The expense must be for a routine care of the eye, not for surgery or medical care.
3. The expense must be for a vision service or materials included in VISION CARE THAT IS COVERED. Additional limits on *covered vision expense* are included under specific benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a vision service or materials listed in VISION CARE THAT IS NOT COVERED. If the service or materials are partially excluded, then only that portion which is not excluded will be considered *covered vision expense*.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
6. All services and materials must be ordered by a licensed ophthalmologist, optometrist or dispensing optician.

## VISION CARE THAT IS COVERED

Subject to the Vision Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under VISION CARE THAT IS NOT COVERED, we will provide benefits for the following services and materials:

**Vision Examination.** A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of correction eyewear where indicated. This does not include contact lens fitting fee.

**Frames.** The *vision care provider* will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency. If you go to a *participating vision care provider* and you choose frames that cost more than the benefit maximum shown under SUMMARY OF BENEFITS: VISION CARE BENEFIT MAXIMUMS, your cost will be based on a discounted arrangement.

**Lenses.** The *vision care provider* will order the proper lenses necessary for your visual welfare. The *vision care provider* will verify the accuracy of the finished lenses. Covered lenses include plastic (CR39):

1. Single vision;
2. Bifocal;
3. Trifocal (FT25-28);
4. Progressive lenses; or
5. Lenticular lenses.

Benefits include photochromic lenses, polycarbonate lenses, tinted lenses and factory scratch coating. All other coating, other lens materials and treatments are not covered benefits. You will be responsible for amounts in excess of the Vision Care Benefit Maximum.

**Elective Contact Lenses.** You have an allowance per benefit period toward cosmetic contact lenses selected in lieu of the eyeglass lens benefit. If you choose contact lenses greater than the *plan* allowance, you are responsible for the difference. If you choose to receive contact lenses during a benefit period, no benefits will be paid for lenses during that same benefit period.

**Non-Elective Contact Lenses.** Non-elective lenses are provided for reasons that are not cosmetic in nature and have a maximum benefit per benefit period. Non-elective contact lenses are covered when the following conditions have been identified or diagnosed:

1. Extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses; or
2. Keratoconus - unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; or
3. High Ametropia - unusually high levels of near sightedness, far sightedness, or
4. Anisometropia - when one eye requires a much different prescription than the other eye.

**Low Vision.** Low vision is a significant loss of vision, but not total blindness. Providers specializing in low vision care can evaluate and prescribe optical devices, and provide training instruction to maximum the remaining usable vision for our members with low vision. Low vision benefits are only available when you use a *participating vision care provider*.

#### **VISION CARE THAT IS NOT COVERED**

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

**Experimental or Investigative.** Any *experimental* or *investigative* services or materials.

**Crime or Nuclear Energy.** Conditions that result from: (1) your commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

**Uninsured.** Services received before your *effective date* or after your coverage ends.

**Non-Licensed Vision Care Providers.** Treatment or services rendered by non-licensed *vision care providers* and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed *vision care provider* under the supervision of a licensed physician or licensed *vision care provider*, except as specifically provided or arranged by us.

**Excess Amounts.** Any amounts in excess of *covered vision expense*.

**Routine Exams or Tests.** Routine examinations required by an employer in connection with your employment.

**Work-Related.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.

**Government Treatment.** Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this *plan* is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.

**Services of Relatives.** Professional services or supplies received from a person who lives in your home or who is related to you by blood or marriage.

**Voluntary Payment.** Services for which you are not legally obligated to pay. Services for which you are not charged. Services for which no charge is made in the absence of insurance coverage.

**Not Specifically Listed.** Services not specifically listed in this *plan* as covered services.

**Private Contracts.** Services or supplies provided pursuant to a private contract between the *insured person* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

**Eye Surgery.** Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

**Sunglasses.** Sunglasses and accompanying frames.

**Safety Glasses.** Safety glasses and accompanying frames.

**Hospital Care.** Inpatient or outpatient hospital vision care.

**Orthoptics.** Orthoptics or vision training and any associated supplemental testing.

**Non-Prescription Lenses.** Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

**Cosmetic Options.** Blended lenses/no line, oversize lenses, progressive multifocal lenses, photochromatic lens, tinted lenses, except as

specifically stated in the “lenses” provision of VISION CARE THAT IS COVERED, coated lenses, except factory scratch coating, cosmetic lenses or processes, and UV-protected lenses.

**Lost or Broken Lenses or Frames.** Any lost or broken lenses or frames, unless you have reached a new benefit period.

## HOW COVERAGE BEGINS AND ENDS

### HOW COVERAGE BEGINS

#### ELIGIBLE STATUS

1. **Insured Employees.** You are in an eligible status if you are a *retired employee* and eligible to receive health plan benefits as part of the *group’s* pension plan.
2. **Family Members.** The following are eligible to enroll as *family members*: (a) Either the *employee’s spouse* or *domestic partner*; and (b) A *child*.

#### Definition of Family Member

1. **Spouse** is the *retired employee’s* spouse under a legally valid marriage. Spouse does not include any person who is: (a) covered as a *retired employee* or *domestic partner*; or (b) in active service in the armed forces.
2. **Domestic partner** is the *retired employee’s* domestic partner under a legally registered and valid domestic partnership. Domestic partner does not include any person who is: (a) covered as a *retired employee*; or (b) in active service in the armed forces.

For a domestic partnership, other than one that is legally registered and valid, in order for the *retired employee* to include their domestic partner as a *family member*, the *retired employee* and domestic partner must provide the *group* with a signed LACERS domestic partnership affidavit.

3. **Child** is the *retired employee’s, spouse’s* or *domestic partner’s* unmarried natural child, stepchild, grandchild, legally adopted child, or a child for whom the *retired employee, spouse* or *domestic partner* has been appointed legal guardian by a court of law, subject to the following:
  - a. The child is under 26 years of age.
  - b. The unmarried child is 26 years of age, or older and: (i) was covered under the *prior plan*, was covered as a *family member* of the *employee* under another plan or health insurer, or has six or



more months of other *creditable coverage*, (ii) is chiefly dependent on the retired *employee, spouse or domestic partner* for support and maintenance, and (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. We must receive the certification, at no expense to us, within 60-days of the date the *employee* receives our request. We may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent on the retired *employee, spouse or domestic partner* for support and maintenance due to a continuing physical or mental condition. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

- c. A child who is in the process of being adopted is considered a legally adopted child if we receive legal evidence of both: (i) the intent to adopt; and (ii) that the *retired employee, spouse or domestic partner* have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption. Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the *retired employee's, the spouse's or the domestic partner's* right to control the health care of the child.
- d. A child for whom the *retired employee, spouse or domestic partner* is a legal guardian is considered eligible on the date of the court decree (the "eligibility date"). We must receive legal evidence of the decree.
- e. The term "child" does not include any person who is: (i) covered as a *retired employee*; or (ii) in active service in the armed forces.
- f. If both parents are covered as *retired employees*, their children may be covered as the *family members* of either, but not of both.

#### **ELIGIBILITY DATE**

1. **For Employees:** You become eligible for coverage in accordance with rules established by your employer. For specific information

about your employer's eligibility rules for coverage, please contact your Human Resources or Benefits Department.

2. **For Family Members:** You become eligible for coverage on the later of: (a) the date the *employee* becomes eligible for coverage; or (b) the date you meet the *family member* definition.

If, after you become covered under this *plan*, you cease to be eligible due to termination of employment, and you return to an eligible status within six months after the date your employment terminated, you will become eligible to re-enroll for coverage on the first day of the month following the date you return.

## ENROLLMENT

To enroll as a *retired employee*, or to enroll *family members*, the *retired employee* must properly file an application. An application is considered properly filed, only if it is personally signed, dated, and given to the *group* within 60 days from your eligibility date. We must receive this application from the *group* within 90 days. If any of these steps are not followed, your coverage may be denied.

## EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of premium on your behalf. The date you become covered is determined as follows:

1. **Timely Enrollment.** If you enroll for coverage before, on, or within 60 days after your eligibility date, then your coverage will begin as follows: (a) for *retired employees*, on your eligibility date; and (b) for *family members*, on the later of (i) the date the *retired employee's* coverage begins, or (ii) the first day of the month after the *family member* becomes eligible. If you become eligible before the *policy* takes effect, coverage begins on the effective date of the *policy*, provided the enrollment application is on time and in order.
2. **Late Enrollment.** If you fail to enroll within 60 days after your eligibility date, you must wait until the *group's* next Open Enrollment Period to enroll.
3. **Disenrollment.** If you voluntarily choose to disenroll from coverage under this *plan*, you will be eligible to reapply for coverage as set forth in the "Enrollment" provision above, during the *group's* next Open Enrollment period (see OPEN ENROLLMENT PERIOD).

For late enrollees and disenrollees: You may enroll earlier than the *group's* next Open Enrollment Period if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

## Special Enrollment Periods

You may enroll without waiting for the *group's* next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
  - a. You were covered as an individual or dependent under either:
    - i. Another employer group vision plan or vision insurance coverage, including coverage under a COBRA continuation; or
    - ii. A state Medicaid plan or under a state child health insurance program (SCHIP), including the Healthy Families Program or Access for Infants and Mothers (AIM) Program.
  - b. Your coverage under the other vision plan wherein you were covered as an individual or dependent ended as follows:
    - i. If the other vision plan was another employer group vision plan or vision insurance coverage, including coverage under a COBRA continuation, coverage ended because you lost eligibility under the other plan, your coverage under a COBRA continuation was exhausted, or employer contributions toward coverage under the other plan terminated. You must properly file an application with the *group* within 60 days after the date your coverage ends or the date employer contributions toward coverage under the other plan terminate.  
  
Loss of eligibility for coverage under an employer group vision plan or vision insurance includes loss of eligibility due to termination of employment or change in employment status, reduction in the number of hours worked, loss of dependent status under the terms of the *plan*, termination of the other plan, legal separation, divorce, death of the person through whom you were covered, and any loss of eligibility for coverage after a period of time that is measured by reference to any of the foregoing.
    - ii. If the other vision plan was a state Medicaid plan or a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program, coverage ended because you lost eligibility under the program. You must properly file an application with the *group* within 60 days after the date your coverage ended.

2. A court has ordered coverage be provided for a *spouse*, *domestic partner* or dependent *child* under your employee vision plan and an application is filed within 60 days from the date the court order is issued.
3. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a *child*:
  - a. If you are enrolling following marriage or domestic partnership, you and your new *spouse* or *domestic partner* must enroll within 31 days of the date of marriage or domestic partnership. Your *domestic partner* must meet the *plan's* eligibility requirements for *domestic partners* as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS. Your new *spouse* or *domestic partner's* children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above.
  - b. If you are enrolling following the birth, adoption, or placement for adoption of a *child*, your *spouse* (if you are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption.
4. You are an employee who is a reservist as defined by state or federal law, who terminated coverage as a result of being ordered to military service as defined under state or federal law, and apply for reinstatement of coverage following reemployment with your employer. Your coverage will be reinstated without any waiting period. The coverage of any dependents whose coverage was also terminated will also be reinstated. For dependents, this applies only to dependents who were covered under the plan and whose coverage terminated when the employee's coverage terminated. Other dependents who were not covered may not enroll at this time unless they qualify under another of the circumstances listed above.
5. The date the *retired employee* reaches the age of 55.

**Effective date of coverage.** For enrollments during a special enrollment period as described above, coverage will be effective on the first day of the month following the date you file the enrollment application, except as specified below:

1. If a court has ordered that coverage be provided for a dependent *child*, coverage will become effective for that *child* on the earlier of (a) the first day of the month following the date you file the enrollment

application or (b) within 30 days after we receive a copy of the court order or of a request from the district attorney, either parent or the person having custody of the *child*, the employer, or the *group* administrator.

2. For enrollments following the birth, adoption, or placement for adoption of a *child*, coverage will be effective as of the date of birth, adoption, or placement for adoption.
3. For reservists and their dependents applying for reinstatement of coverage following reemployment with the employer, coverage will be effective as of the date of reemployment.

#### **OPEN ENROLLMENT PERIOD**

The *group* has an open enrollment period once each *year*, during the month of October. During that time, an individual who meets the eligibility requirements as a *retired employee* under this *plan* may enroll. A *retired employee* may also enroll any eligible *family members* at that time. Persons eligible to enroll as *family members* may enroll only under the *retired employee's plan*.

For anyone so enrolling, coverage under this *plan* will begin on the first of January following your Open Enrollment. Coverage under the former plan ends when coverage under this *plan* begins.

#### **HOW COVERAGE ENDS**

Your coverage ends, without notice from us, as provided below:

1. If the *policy* terminates, your coverage ends at the same time. The *policy* may be cancelled or changed without notice to you.
2. If the *group* no longer provides coverage for the class of *insured persons* to which you belong, your coverage ends on the effective date of that change. If this *policy* is amended to delete coverage for *family members*, a *family member's* coverage ends on the effective date of that change.
3. Coverage for *family members* ends when the *retired employee's* coverage ends.
4. Coverage ends at the end of the period for which premium has been paid to us on your behalf when the required premium for the next period is not paid.
5. If you voluntarily cancel coverage at any time, coverage ends on the premium due date coinciding with or following the date of voluntary cancellation, as provided by written notice to us.

6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends as of the premium due date coinciding with or following the date you cease to meet such requirements.

**Exceptions to Item 6:**

- a. **Leave of Absence.** If you are a *retired employee* and the *group* pays premium to us on your behalf, your coverage may continue for up to six months during a temporary leave of absence approved by the *group*. This time period may be extended if required by law.
- b. **Handicapped Children.** If a *child* reaches the age limit shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan*, (ii) chiefly dependent on the *retired employee*, *spouse* or *domestic partner* for support and maintenance, and (iii) incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the *child* has a physical or mental condition that makes the *child* incapable of obtaining self-sustaining employment. We will notify the *retired employee* that the *child's* coverage will end when the *child* reaches the *plan's* upper age limit at least 90-days prior to the date the *child* reaches that age. The *retired employee* must send proof of the *child's* physical or mental condition within 60-days of the date the *retired employee* receives our request. If we do not complete our determination of the *child's* continuing eligibility by the date the *child* reaches the *plan's* upper age limit, the *child* will remain covered pending our determination. When a period of two years has passed, we may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *retired employee*, *spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

**Note:** If a marriage or domestic partnership terminates, the *retired employee* must give or send to the *group* written notice of the termination. Coverage for a former *spouse* or *domestic partners*, and their dependent *children*, if any, ends according to the "Eligible Status" provisions. If Anthem Blue Cross Life and Health suffers a loss because of the *retired employee* failing to notify the *group* of the termination of their marriage or domestic partnership, Anthem Blue Cross Life and Health may seek recovery from the *retired employee* for any actual loss resulting thereby. Failure to provide written notice to the *group* will not delay or prevent

termination of the marriage or domestic partnership. If the *retired employee* notifies the *group* in writing to cancel coverage for a former *spouse* or *domestic partner* and the children of the *spouse* or *domestic partner*, if any, immediately upon termination of the *retired employee's* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE.

## CONTINUATION OF COVERAGE

Most employers who employ 20 or more people on a typical business day are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the *policy* is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to a period of continuation of coverage. Check with your employer for details. Your employer must provide you with the name of your Health Plan Administrator. Your Health Plan Administrator will give you notice of your right to continue coverage after certain "Qualifying Events". You must notify your health Plan Administrator of the occurrence of any subsequent Qualifying Events. (See the "Terms of COBRA Continuation" provision below.)

## DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "Definitions" provision.

**Initial Enrollment Period** is the period of time following the original Qualifying Event, as indicated in the "Terms of COBRA Continuation" provisions below.

**Qualified Beneficiary** means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *policy* as either an *insured employee* or *insured family member*; and (b) a *child* who is born to or placed for adoption with the *insured employee* during the COBRA continuation period. Qualified Beneficiary does not include: (a) any person who was not enrolled during the Initial Enrollment Period, including any *family members* acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above; or (b) a *domestic partner*, or a *child* of a *domestic partner*, if they are eligible under HOW COVERAGE BEGINS AND ENDS.

**Qualifying Event** means any one of the following circumstances which would otherwise result in the termination of your coverage under the *policy*. The events will be referred to throughout this section by number.

**1. For Insured Employees and Insured Family Members:**

- a. The *employee's* termination of employment, for any reason other than gross misconduct; or
- b. Loss of coverage under an employer's health plan due to a reduction in the *employee's* work hours.

**2. For Retired Employees and their Insured Family Members.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *group's* filing for Chapter 11 bankruptcy, provided:

- a. The *policy* expressly includes coverage for retirees; and
- b. Such cancellation or reduction of benefits occurs within one year before or after the *group's* filing for bankruptcy.

**3. For Insured Family Members:**

- a. The death of the *insured employee*;
- b. The *spouse's* divorce or legal separation from the *employee*;
- c. The end of a *child's* status as a dependent *child*, as defined by the *policy*; or
- d. The *employee's* entitlement to Medicare.

**ELIGIBILITY FOR COBRA CONTINUATION**

An *insured employee* or *insured family member*, **other than a *domestic partner*, and a *child of a domestic partner***, may choose to continue coverage under the *policy* if his or her coverage would otherwise end due to a Qualifying Event.

**TERMS OF COBRA CONTINUATION**

**Notice.** The Health Plan Administrator (we are not the administrator) will notify either the *insured employee* or *insured family member* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the *employee* will be notified of the right to continue coverage.
2. For Qualifying Events 3(a) or 3(e) above, a *family member* will be notified of the COBRA continuation right.



3. For Qualifying Events 3(b), 3(c), or 3(d) above, you must inform the Health Plan Administrator within 60 days of the Qualifying Event if you wish to continue coverage. The Health Plan Administrator, in turn, will promptly give you official notice of the continuation right.

If you choose to continue coverage you must notify us within 60 days of the date you receive notice of your COBRA continuation right from your Health Plan Administrator. The COBRA continuation coverage may be chosen for all *insured persons* within a family, or only for selected *insured persons*.

If you fail to elect the COBRA continuation during the Initial Enrollment Period, you may not elect the COBRA continuation at a later date.

You must remit the initial premium to us within 45 days after you elect COBRA continuation coverage.

**Additional Insured Family Members.** A *spouse* or *child* acquired during the COBRA continuation period is eligible to be enrolled as a *family member*. The standard enrollment provisions of the *policy* apply to enrollees during the COBRA continuation period.

**Cost of Coverage.** You are required to pay the entire cost of your COBRA continuation coverage. You must remit this cost (called the "premium") to us each month during the COBRA continuation period. In addition to the premium, we will add a monthly administrative fee equal to two percent of the premium rate. We must receive payment of the premium and administrative fee each month in order to maintain the coverage in force.

Besides applying to the *insured employee*, the *employee's* premium rate will also apply to:

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *employee*;
2. A *domestic partner* whose COBRA continuation began due to the end of the domestic partnership or death of the *employee*;
3. A *child*, if neither the *employee* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the premium will be the two-party or three-party rate depending on the number of *children* enrolled); and
4. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

**Payment Dates.** The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. We will bill you for any retroactive charges which may be due. Succeeding premiums are due on the first day of each following month (the Premium Due Date).

**Grace Period.** For every Premium Due Date, except the first, there is a 31-day grace period in which to pay premiums. If premiums are not received by the end of the grace period, your coverage will be canceled at the end of the period for which premiums are last paid.

**Premium Rate Change.** The premium rates may be changed by us as of any Premium Due Date. Your Health Plan Administrator agrees to provide you with written notice at least 60 days prior to the date any premium rate increase goes into effect.

**Subsequent Qualifying Events.** Once covered under the COBRA continuation, it's possible for a second Qualifying Event to occur. If that happens, an *insured person*, who is a Qualified Beneficiary, may be entitled to an extended COBRA continuation period. This period will in no event continue beyond 36 months from the date of the first qualifying event.

For example, a *child* may have been originally eligible for this COBRA continuation due to termination of the *insured employee's* employment, and was enrolled for this COBRA continuation as a Qualified Beneficiary. If, during the COBRA continuation period, the *child* reaches the upper age limit of the *plan*, the *child* is eligible for an extended continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

**When COBRA Continuation Coverage Begins.** When COBRA continuation coverage is elected during the Initial Enrollment Period and the premium is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For *family members* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *policy*.

**When the COBRA Continuation Ends.** This COBRA continuation will end on the earliest of:

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;\*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *insured employee*, divorce or legal separation, or the end of dependent *child* status;\*

3. The end of 36 months from the date the *insured employee* became entitled to Medicare, if the Qualifying Event was the *employee's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *insured employee* will end 36 months from the date the *insured employee* became entitled to Medicare;
4. The date the *policy* terminates;
5. The end of the period for which premiums are last paid;
6. The date, following the election of COBRA, the *insured person* first becomes covered under any other group health plan; or
7. The date, following the election of COBRA, the *insured person* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

\*For an *insured person* whose COBRA continuation coverage began under a *prior plan*, this term will be dated from the time of the Qualifying Event under that *prior plan*.

Subject to the *policy* remaining in effect, a retired *employee* whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered *family members* may continue coverage for 36 months after the *employee's* death. However, coverage could terminate prior to such time for either *employee* or *family member* in accordance with items 4, 5 or 6 above.

#### **EXTENSION OF CONTINUATION DURING TOTAL DISABILITY**

If at the time of termination of employment or reduction in hours, or at any time during the first 60 days of the COBRA continuation, a Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered *insured persons* may be entitled to up to 29 months of continuation coverage after the original Qualifying Event.

**Eligibility for Extension.** To continue coverage for up to 29 months from the date of the original Qualifying Event, the disabled *insured person* must:

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and
2. Be determined and certified to be so disabled by the Social Security Administration.

**Notice.** The *insured person* must furnish us with proof of the Social Security Administration's determination of disability during the first 18 months of the COBRA continuation period and no later than 60 days after the later of the following events:

1. The date of the Social Security Administration's determination of the disability;
2. The date on which the original Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses coverage; or
4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

**Cost of Coverage.** For the 19th through 29th months that the total disability continues, you must remit to us the cost for the extended continuation coverage. This cost (called the "premium") shall be subject to the following conditions:

1. If the disabled *insured person* continues coverage during this extension, this cost shall be **150%** of the applicable rate for the length of time the disabled *insured person* remains covered, depending upon the number of covered dependents. If the disabled *insured person* does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.
2. You are required to pay the entire cost of the extended continuation coverage.
3. You must remit the cost for extended continuation coverage to us each month. We must receive your timely payment of the premium each month in order to maintain the coverage in force.

If a second Qualifying Event occurs during this extended continuation, the total COBRA continuation may continue for up to 36 months from the date of the first Qualifying Event. The premium rate shall then be **150%** of the applicable rate for the 19th through 36th months if the disabled *insured person* remains covered. The charge will be **102%** of the applicable rate for any periods of time the disabled *insured person* is not covered following the 18th month.

**When The Extension Ends.** This extension will end at the earlier of:

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;
2. The end of 29 months from the Qualifying Event;

3. The date the *policy* terminates;
4. The end of the period for which premiums are last paid;
5. The date, following the election of COBRA, the *insured person* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *insured person*, in which case this COBRA extension will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
6. The date, following the election of COBRA, the *insured person* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

You must inform the Health Plan Administrator within 30 days of a final determination by the Social Security Administration that you are no longer totally disabled.

## GENERAL PROVISIONS

**Providing of Care.** We are not responsible for providing any type of vision care, nor are we responsible for the quality of any such care received.

**Independent Contractors.** Our relationship with providers is that of an independent contractor. Ophthalmologists, optometrists and dispensing opticians are not our agents nor are we or any of our employees, an employee or agent of any *vision care provider* of any type.

**Non-Regulation of Providers.** The benefits of this *plan* do not regulate the amounts charged by providers of vision care, except to the extent that rates for covered services are regulated with *participating vision care providers*.

### Terms of Coverage

1. In order for you to be entitled to benefits under the *policy*, both the *policy* and your coverage under the *policy* must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The *policy* is subject to amendment, modification or termination according to the provisions of the *policy* without your consent or concurrence.

**Nondiscrimination.** No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

**Protection of Coverage.** We do not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; and (3) your premiums are paid according to the terms of the *policy*.

**Free Choice of Provider.** This *plan* in no way interferes with your right as an *insured person* entitled to vision care benefits to select a *vision care provider*. You may choose any *vision care provider* which provides care covered under this *plan*, and is properly licensed according to appropriate state and local laws. But your choice may affect the benefits payable according to this *plan*.

**Expense in Excess of Benefits.** We are not liable for any expense you incur in excess of the benefits of this *plan*.

**Benefits Not Transferable.** Only *insured persons* are entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

**Notice of Claim and Proof of Loss.** You or the *vision care provider* must send us an itemized bill within 90 days of the date you receive the service or supply for which claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. Except in the absence of legal capacity, we are not liable for the benefits of the *plan* if you do not file claims within the required time period. We will not be liable for benefits if we do not receive written proof of loss on time. Canceled checks or receipts are not acceptable.

**Timely Payment of Claims.** Any benefits due under this *plan* shall be due once we have received proper, written proof of loss, together with such reasonably necessary additional information we may require to determine our obligation.

**Payment to Providers.** We will pay the benefits of this *plan* directly to *participating vision care providers*. Also, we will pay *non-participating vision care providers* directly when you assign benefits in writing. These payments will fulfill our obligation to you for those covered services.

**Right of Recovery.** Whenever payment has been made in error, we will have the right to make appropriate adjustment to claims, recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event we recover a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, we will only recover such payment from the

provider within 365 days of the date we made the payment on a claim submitted by the provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if we pay your healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, we may collect such amounts directly from you. You agree that we have the right to recover such amounts from you.

We have oversight responsibility for compliance with provider and vendor and subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome.

**Plan Administrator - COBRA and ERISA.** In no event will we be plan administrator for the purposes of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the *group* or to a person or entity other than us, engaged by the *group* to perform or assist in performing administrative tasks in connection with the *group's* health plan. The *group* is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this booklet, the *group* is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

**Workers' Compensation Insurance.** The *policy* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

**Entire Contract.** This certificate, including any amendments and endorsements to it, is a summary of your benefits. It replaces any older certificates issued to you for the coverages described in the Summary of Benefits. All benefits are subject in every way to the entire *policy* which includes this certificate. The terms of the *policy* may be changed only by a written endorsement signed by one of our authorized officers. No agent or employee has any authority to change any of the terms, or waive the provisions of, the *policy*.

**Liability For Statements.** No statements made by you, unless they appear on a written form signed by you or are fraudulent, will be used to deny a claim under the *policy*. Statements made by you will not be deemed warranties. With regard to each statement, no statement will be used by us in defense to a claim unless it appears in a written form signed by you and then only if a copy has been furnished to you. After two years following the filing of such claim, if the coverage under which such claim is filed has been in force during that time, no such statement will be used to deny such a claim, unless the statement is fraudulent.

**Physical Examination.** At our expense, we have the right and opportunity to examine any *insured person* claiming benefits when and as often as reasonably necessary while a claim is pending.

**Legal Actions.** No attempt to recover on the *plan* through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this *plan*. No such action may be started later than three years from the time written proof of loss is required to be furnished.

**Conformity with Laws.** Any provision of the *policy* which, on its effective date, is in conflict with the laws of the governing jurisdiction, is hereby amended to conform to the minimum requirements of such laws.

**Financial Arrangements with Providers.** Under arrangements with some health care providers and suppliers (hereafter referred to together as "Providers") certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, vision services rebates, may be based on utilization of specific Providers for specified vision services rendered to all persons who have coverage through a similar vision program provided or administered by Anthem Blue Cross Life and Health or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by Anthem Blue Cross Life and Health or an affiliate in determining its fees or subscription charges or premiums.

## **BINDING ARBITRATION**

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or the *policy*, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or



is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

The *insured person* and Anthem Blue Cross Life and Health agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

The *insured person* and Anthem Blue Cross Life and Health agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the *insured person* waives any right to pursue, on a class basis, any such controversy or claim against Anthem Blue Cross Life and Health and Anthem Blue Cross Life and Health waives any right to pursue on a class basis any such controversy or claim against the *insured person*.

The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the *insured person* making written demand on Anthem Blue Cross Life and Health. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the *insured person* and Anthem Blue Cross Life and Health, or by order of the court, if the *insured person* and Anthem Blue Cross Life and Health cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem Blue Cross Life and Health will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to Anthem Blue Cross Life and Health Insurance Company, P.O. Box 4310, Woodland Hills, CA 91365-4310 marked to the attention of the Member services Department listed on your identification card.

## **DEFINITIONS**

The meanings of key terms used in this certificate are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in your certificate, you should refer to this section.

**Child** meets the *plan's* eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

**Contributory Insurance; non-contributory insurance.** Contributory insurance is insurance for which the *group* has the right to require your contributions. Non-contributory insurance is insurance for which the *group* does not have the right to require your contributions. The Summary of Benefits shows whether insurance under a coverage is *contributory insurance* or *non-contributory insurance*.

**Covered vision expense** is the expense you incur for a covered service or materials, but not more than the maximum amounts described in YOUR VISION CARE BENEFITS: HOW COVERED VISION EXPENSE IS DETERMINED. Expense is incurred on the date you receive the service or materials.

**Creditable coverage** is any individual or group plan that provides medical, hospital and surgical coverage, including continuation coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition. In addition, eligible children were covered under one of the above types of health coverage on his or her own and not as a dependent *child*.

If your prior coverage was through an employer, you will receive credit for that coverage if it ended because your employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer's contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 180 days (not including any waiting period imposed under this *plan* by the employer).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 63 days (not including any waiting period imposed under this *plan* by the employer).

**Domestic partner** meets the *plan's* eligibility requirements for domestic partners as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

**Effective date** is the date your coverage begins under this *plan*.

**Experimental** procedures are those that are mainly limited to laboratory and/or animal research.

**Full-time employee** meets the *plan's* eligibility requirements for full-time employees as outlined under HOW COVERAGE BEGINS AND ENDS.

**Group** refers to the business entity to which we have issued this *policy*. The name of the group is LOS ANGELES CITY EMPLOYEES' RETIREMENT SYSTEM.

**Insured employee (employee)** is the primary insured; that is, the person who is allowed to enroll under this *plan* for himself or herself and his or her eligible *family members*.

**Insured family member (family member)** meets the *plan's* eligibility requirements for family members as outlined under HOW COVERAGE BEGINS AND ENDS.

**Insured person** is the *insured employee* or *insured family member*. An insured person may enroll under only one health plan provided by Anthem Blue Cross Life and Health, or any of its affiliates, which is sponsored by the *group*.

**Investigative** procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

**Negotiated rate** is the amount *participating vision care providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Preferred Provider Organization Plan Participating Agreements.

**Non-participating vision care provider** is a provider which does not have a Preferred Provider Agreement with us at the time services are rendered.

**Participating vision care provider** is a provider which has a Preferred Provider Organization Plan Participating Agreement in effect with us at the time services are rendered. Participating vision care providers agree to accept the *negotiated rate* as payment for covered services.

**Plan** is the set of benefits described in this booklet and in the amendments to this booklet (if any). This plan is subject to the terms and conditions of the *policy* we have issued to the *group*. If changes are made to the plan,

an amendment or revised booklet will be issued to the *group* for distribution to each *employee* affected by the change. (The word "plan" here does not mean the same as "plan" as used in ERISA.)

**Policy** is the Group Policy we have issued to the *group*.

**Prior plan** is a plan sponsored by the *group* which was replaced by this *plan* within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

**Retired employee** is a former *full-time employee* who meets the eligibility requirements described in the "Eligible Status" provision in HOW COVERAGE BEGINS AND ENDS.

**Spouse** meets the *plan's* eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

**Totally disabled retired employee** is a *retired employee* who is unable to perform all activities usual for persons of that age.

**Vision care provider** is an ophthalmologist, optometrist or dispensing optician who is licensed to practice vision care, is rendering a service within the scope of the license and is providing a service for which benefits are specified in this booklet.

**We (us, our)** refers to Anthem Blue Cross Life and Health Insurance Company or Anthem Blue Cross (an affiliate of Anthem Blue Cross Life and Health).

**Year** or **calendar year** is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

**You (your)** refers to the *insured employee* and *insured family members* who are enrolled for benefits under this *plan*.



# Get help in your language

## Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:

**IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

### Spanish

Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

### Arabic

يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بمترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721. للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 927-4357-1-800 (TTY/TDD: 711).

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

MCASH4788CML 06/16 CDI3 CDIW1

## Armenian

Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357: (TTY/TDD: 711)

## Chinese

免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者1-888-254-2721聯絡我們。如需更多協助，請撥打1-800-927-4357 聯絡CA Dept. of Insurance。(TTY/TDD: 711)

## Farsi

خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخوانید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721 با ما تماس بگیرید. برای دریافت کمک‌های بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. (TTY/TDD: 711)

## Hindi

बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपको आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग को कॉल करें। (TTY/TDD: 711)

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

MCASH4788CML 06/16 CDI3 CDIW1

**Hmong**

Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntauv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntauv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

**Japanese**

無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局(1-800-927-4357)にお電話ください。(TTY/TDD: 711)

**Khmer**

សេវាភាសាភីក្រសួង អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់។ អ្នកអាចឱ្យគេអានឯកសារផ្សេងៗជូនអ្នក និងផ្ញើឯកសារជូនអ្នកជាការសរសេរអ្នក។ ដើម្បីទទួលបានស្នូមហៅទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើប័ណ្ណ ID របស់អ្នក ឬក៏លេខ 1-888-254-2721។ ដើម្បីទទួលបានស្នូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។(TTY/TDD: 711)

**Korean**

무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

**Punjabi**

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਬਾਸੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਜ਼ਿਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਡਿਪਾਰਟਮੈਂਟ ਔਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

#### Russian

Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочитать документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

#### Tagalog

Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

#### Thai

ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการสามได้  
ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึง  
ท่านโดยใช้ภาษาของท่าน หากต้องการความช่วยเหลือ  
โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข  
1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก  
CA Dept. of Insurance ที่หมายเลข 1-800-927-4357. (TTY/TDD: 711)

#### Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (TTY/TDD: 711)

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.



### **It's important we treat you fairly**

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.