



CICV Benefits Consortium

Vision Plan Group Policy

Take Control of Your Health

Your Anthem Plan

**ANTHEM BLUE CROSS AND BLUE SHIELD
Richmond, Virginia**

GROUP INSURANCE POLICY

This policy is issued to (Policyholder):	CICV Benefits Consortium
Policy Number:	41901400
Policy Effective Date:	01/01/2010
Renewal Date:	01/01/2011

Anthem Blue Cross and Blue Shield (Anthem) agrees that covered persons under this policy shall be provided the benefits set forth herein, subject to its terms and conditions for a period beginning at 12:01 a.m. on the policy date, and ending at 12:00 Midnight on the date prior to the renewal date. The policy shall renew from year to year thereafter unless, and until, the policy is terminated. The initial period and each succeeding one-year period shall each be referred to as a policy year. The policy date and the renewal date are set forth above. In consideration of the above, the policyholder agrees to pay the premiums provided for in this policy; to receive on behalf of, and deliver to, its enrollees membership cards and all notices from Anthem; and to perform the obligations imposed upon it as agent of its enrollees under this policy.

ANTHEM HEALTH PLANS OF VIRGINIA, INC.
d/b/a ANTHEM BLUE CROSS AND BLUE SHIELD



C. Burke King
President

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. •An independent licensee of the Blue Cross and Blue Shield Association.

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I. INCORPORATION OF PROVISIONS

The entire contract between the parties consists of: (a) this policy; (b) the application of the policyholder, if any; (c) the individual applications of the persons insured, if any; (d) the individual certificates issued by Anthem (certificates); and (e) any attached riders and endorsements to the policy or certificates.

The documents described in (b) through (e) above are made a part of this policy.

II. ELIGIBILITY FOR COVERAGE

Each person who is an eligible enrollee (as defined below) may be insured under the policy. The requirements for becoming insured and the requirements for insuring dependents are described in the certificates.

“Eligible enrollee” means a person who is determined to be eligible for coverage under this policy by the policyholder, consistent with guidelines set by Anthem. Unless otherwise agreed in writing by Anthem, a person may not be an eligible enrollee unless he or she:

- A. is a full-time active employee of the policyholder or an entity under at least 51% common ownership with the policyholder; or
- B. is eligible for continuation of coverage under state or federal law such as COBRA; or
- C. is a retiree who is eligible for coverage as defined by the policyholder, when Anthem has agreed to provide retiree coverage.

The term “full-time active employee” used above means an individual (including but not limited to an owner, partner, director or officer) who works for pay or profit at least 25 hours per week, 50 weeks per year. It also includes (1) an employee who has been absent from work due to illness or injury for up to 6 months; and (2) an employee who has been absent from work due to leave of absence or layoff for up to 12 weeks.

The date on which a person becomes an eligible enrollee shall be determined by the policyholder.

The following are examples of individuals who are not eligible for coverage:

- part time employees;
- temporary employees;
- independent contractors;
- retirees, unless Anthem has agreed to provide retiree coverage as described above;
- any employee who has been absent from work due to illness or injury for more than 6 months;
- any employee who has been absent from work due to leave of absence or temporary layoff for more than 12 weeks;
- unpaid workers; and
- employees who have not met the waiting period for eligibility imposed by the policyholder, if any.

III. GENERAL PROVISIONS

A. Changes to the policy

No change in this policy will be effective until approved in writing by an Anthem officer or his or her authorized designee. No agent or representative of Anthem, other than an Anthem officer or his or her designee, may change this policy or waive any of its provisions.

B. Benefits To Which Covered Persons Are Entitled

A covered person will receive benefits for covered services set forth in this policy. The extent to which a covered person is entitled to benefits under the policy shall be determined by Anthem in its sole discretion.

C. Records of and Changes in Covered Person's Eligibility

1. The policyholder must furnish Anthem with any data required by Anthem for coverage for covered persons under this policy. In addition, the policyholder must provide prompt notice to Anthem of the effective date of any changes in a covered person's status under this policy.
2. All notices by the policyholder to Anthem must be furnished on forms approved by Anthem. The notice must include all information reasonably required by Anthem to effect changes.
3. Clerical errors or delays in recording or reporting data will not cancel coverage that would otherwise be in force or continue coverage that would otherwise terminate. Upon discovery of errors or delays, an adjustment of premiums and benefits will be made.
4. The policyholder is liable for the cost of all policy benefits which are provided for services rendered to a terminated covered person after his or her effective date of termination when the policyholder fails to notify Anthem of such termination on or before the termination date.

D. Amendment And Termination Of The Policy

1. Anthem may amend this policy by giving written notice to the policyholder at least 30 days in advance. However, the benefit levels or covered services specified in this policy may not be reduced under this paragraph except on any renewal date of the policy.
2. The policyholder may cancel this policy on the last day of any month by giving written notice to Anthem at least 30 days in advance.
3. This policy may be terminated, at Anthem's option, when:
 - a. the policyholder does not pay the appropriate premium when due. Anthem will notify the policyholder at least 15 days prior to terminating the group policy for non-payment of a monthly premium;
 - b. the policyholder fails to perform any duties required by this policy;

- c. the policyholder commits fraud or misrepresentation with respect to this policy. A covered person's coverage may be terminated for fraud or misrepresentation by the covered person with regard to his or her coverage;
- d. the policyholder fails to comply with underwriting guidelines of Anthem with respect to employer contribution and participation requirements;
- e. there is no longer an enrollee who lives, resides or works in Anthem's service area;
- f. Anthem decides, in accordance with state law, to discontinue offering the particular type of group health coverage specified in this policy, provided that in such instance Anthem gives at least 90 days written notice of its intent to the policyholder and covered persons under the policy; or
- g. Anthem decides, in accordance with state law, to discontinue offering all group health insurance coverage in this state, provided that in such instance Anthem gives at least 180 days written notice of its intent to the Virginia State Corporation Commission, the policyholder, and covered persons under the policy.

If the policyholder is an association offering coverage under this policy to its membership, Anthem may terminate coverage for any subgroup in the association upon the occurrence of any event listed in Paragraph **D.3.a.** through **D.3.e.** above if the failure is attributable to that subgroup. Also, in the event Anthem terminates the policy under Paragraphs **D.3.f.** or **D.3.g.** above, the notice requirements of those paragraphs also apply to each association subgroup.

- 4. Termination of the policy automatically ends all covered persons' coverage. Except as provided in Paragraphs **D.3.f.** and **D.3.g.** of this section, the policyholder must notify all covered persons of the termination of the coverage. However, coverage will end whether or not the notice is given.

E. Termination Of A Covered Person's Coverage Under This Policy

When the covered person ceases to be eligible for coverage, or the required premiums are not paid, the covered person's coverage will end. Unless otherwise agreed in writing by Anthem, the covered person's coverage will end on the last day of the month in which eligibility ends or for which payment was made, whichever is earlier.

F. Payment Of Premiums

Unless otherwise agreed to in writing by Anthem, premiums are required to be paid by the policyholder on a monthly basis by the first day of the month for which coverage is purchased. Premiums are not considered paid until they are received by Anthem. Except as provided in Paragraph **G.** of this section, Anthem will not be responsible for claims incurred by covered persons during any period for which full premiums have not been paid.

G. Grace Period

The policyholder is entitled to a grace period of 31 days for the payment of monthly premiums due except for the first month's premium. During this grace period, the policy will continue in force unless the policyholder gives written notice of termination prior to the effective date of termination. The policyholder will be liable to Anthem for any premium owed for the time the policy is in force during a grace period.

H. Incontestability

The validity of this policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from the policy date indicated on the cover page. No statement made by an enrollee relating to:

- his insurability; or
- the insurability of his dependents;

shall be used in contesting the validity of the coverage of the person about whom the statement was made after coverage has been in force for a period of two years. Any such statement must be submitted in writing and signed by the enrollee.

I. Applications

A copy of the application, if any, shall be attached to the policy when issued. No written statement made by a covered person shall be used in any context unless a copy of the statement is given to the covered person, his beneficiary, or his personal representative. Any statement made by the policyholder or covered person shall be deemed a representation and not a warranty.

J. Misstatement Of Age

If the premiums charged for coverage vary by the age of the covered person, a fair adjustment of premiums shall be made if the age of the covered person has been misstated. Anthem will only be liable to adjust premiums retroactive to the last annual renewal date of this policy.

K. Individual Certificates

Anthem will at its option issue either (1) to the policyholder for delivery to each enrollee, or (2) to each enrollee a certificate setting forth:

1. The enrollee's coverage, including any limitations, reductions and exclusions applicable to the coverage;
2. To whom the insurance benefits are payable;
3. Any family member's or dependent's coverage; and
4. The conversion rights afforded under this policy.

L. Time Of Payment Of Claims

All benefits for a claim under this policy will be payable within 60 days after receipt of written notice. Written notice must include all information that Anthem needs to process a claim.

M. Claim Forms

Anthem will give forms for filing a claim to the person who makes the claim or to the policyholder to distribute. If Anthem does not send these forms within 15 days of its receipt of notice that a claim is to be filed, the person making the claim shall be deemed to comply with the time limits if he files written proof of the occurrence, including the character and extent of the loss for which the claim is made.

N. Physical Examinations And Autopsy

Anthem shall have the right:

- to examine the covered person for whom a claim is made when and as often as it may reasonably require during the pendency of a claim under the policy; and
- to make an autopsy where it is not prohibited by law.

O. Personal Benefits And Assignment Of Payment

1. A covered person may not assign the right to receive payment for covered services. Prior payments to anyone, whether or not there has been an assignment of payment, shall not waive or otherwise restrict, Anthem's right to direct future payments to a covered person or any other entity. This provision shall not apply to dentists and oral surgeons.
2. Once covered services are rendered by a provider, Anthem will not honor requests not to pay the claims submitted by the provider. Anthem will have no liability to any person because it rejects the request.

P. Brochures And/Or Identification Cards

Anthem or the policyholder may provide brochures or booklets that describe this policy's benefits. It may also provide claims filing instructions. In the event of a conflict between this policy and these documents, this policy will prevail.

Q. Applicable Law

This policy is entered into in, and is subject to the laws of, the Commonwealth of Virginia.

R. Notice

Any notice required under this policy must be in writing. Notice given to the policyholder will be sent to the policyholder's address stated in the group application. Notice given to Anthem will be sent to Anthem's address stated in the group application. Notice given to a covered person will be sent, at Anthem's option, either to the policyholder or to the covered person's address as it appears on the records of Anthem. The policyholder, Anthem, or a covered person may, by written notice, indicate a new address for giving notice.

S. Coordination Of Benefits (COB)

All benefits provided under this policy are subject to this provision. However, benefits will not be increased by this COB provision.

This provision applies if the total payment under this policy absent this provision and under any other contract is greater than the value of covered services.

1. The following definition applies to this provision:

Other Contract means any arrangement providing health care benefits or services through:

- group or blanket insurance coverage;
- group Blue Cross Blue Shield, health maintenance organization, and other prepayment coverage;
- coverage under labor management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax supported or government program to the extent permitted by law.

If there is more than one *other contract*, this provision will apply separately to each. If an *other contract* has a coordination of benefits provision that applies to only part of its services, the terms of this paragraph will be applied separately to that part and to any other part.

When benefits are provided in the form of services, the reasonable cash value of each service shall be deemed the benefit.

Anthem will not determine the existence of any *other contract*, or the amount of benefits payable under any *other contract* except this policy. The payment of benefits under this policy shall be affected by the benefits payable under *other contracts* only when Anthem is given information about *other contracts*.

If the rules of this policy and the *other contract* both provide that this policy is primary, then this policy is primary. When Anthem determines that this policy is secondary under the rules described below, benefits will be reduced so that our payment plus the other contract's payment will not exceed Anthem's allowable charge for covered services.

2. Rules for determining primary/secondary status are as follows:

a. If coverage under a contract is taken out in the name of a covered person, then that contract will be primary for that covered person. However, if the person is also entitled to Medicare, and as a result of federal law Medicare is:

- secondary to the contract covering the person as a dependent; and
- primary to the contract covering the person as other than a dependent (e.g., a retired employee);

then the benefits of the contract covering the person as a dependent are determined before those of the contract covering the person as other than a dependent.

b. For children who are covered under both parents' contracts, the following will apply:

- The contract of the parent whose birthday occurs earlier in the calendar year will be primary.
- When parents are separated or divorced, the following special rules will apply:
 - ◆ If the parent with custody has not remarried, that parent's contract will be primary.
 - ◆ If the parent with custody has remarried, that parent's contract will be primary and the stepparent's contract will be secondary. The benefits of the contract of the parent without custody will be determined last.
 - ◆ The rules listed above may be changed by a court decree:
 - A court decree that orders one of the parents to be responsible for health care expenses will cause that parent's contract to be primary, but only if the entity providing the benefits in this case is notified of the court decree before applying benefits.
 - If the court decree does not state that one of the parents is responsible for health care expenses and both parents have joint custody, the contract of the parent whose birthday occurs earlier in the calendar year will be primary.
- If the other contract includes the gender rule, then that rule will be used instead of the rules listed above. The gender rule states that the father's contract will be primary for the children.

c. If there are situations not covered above, then the contract that has been in effect the longest period of time (without interruption) will be primary. There is an exception to this rule. The contract that covers a working employee (or his dependent) will be primary. The policy of a laid-off employee, a retired employee, or a person on continuation of coverage options under federal or state law will be secondary.

d. If another policy has different rules from those listed above other than the gender rule, that policy will be primary.

If payments should have been made under this policy under the rules of this provision, but they have been made under any *other contract*, Anthem may pay an entity (provider, other carrier, etc.) that has paid any amounts it determines will meet the intent of this provision. These amounts shall be deemed to be benefits paid under this policy. Upon this payment, Anthem will no longer be liable under this policy.

T. Right Of Recovery

1. Anthem shall have the right to recover any overpayment of benefits from persons or organizations that Anthem has determined to have realized benefits from the overpayment:
 - any persons to or for whom such payments were made;
 - any insurance company;
 - a facility or provider; or
 - any other organization.
2. The enrollee, on behalf of covered persons enrolled under his or her family coverage, shall cooperate with Anthem to secure its rights to recover the excess payments.

U. Company's Continuing Rights

On occasion, Anthem may not insist on strict performance of all terms of this policy. Failure to apply terms or conditions does not mean Anthem waives or gives up any future rights under this policy.

V. Claims Experience

Upon request by the policyholder, Anthem will provide the policyholder a complete record of the claims paid under this policy. This record shall include all claims incurred for the lesser of:

1. the period of time since the policy was issued or issued for delivery; or
2. the period of time since the policy was last renewed, reissued or extended, if already issued.

This record will be made available promptly to the policyholder upon request made not less than thirty (30) days prior to the date upon which the premiums or contractual terms of the policy may be amended.

W. Covered Persons Entitled To Medicaid Benefits

If a covered person is also entitled to benefits under a state Medicaid program:

1. Payments for covered services rendered to the covered person will be made in accordance with any assignment of rights made by or on behalf of such covered person as required by Medicaid.
2. To the extent that payment has been made under Medicaid for covered services, payment of benefits under this policy will be made in accordance with any state law which provides that the state has acquired the rights with respect to a covered person for payment for such services.

The policyholder shall not take into account whether an individual is entitled to Medicaid when determining whether the individual is an eligible enrollee or eligible dependent.

X. Independent Corporation

By accepting this policy, the policyholder agrees to the following:

1. This agreement constitutes a contract solely between the policyholder and Anthem.
2. Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association).
3. Anthem is permitted to use the Blue Cross and Blue Shield Service Marks in a portion of the Commonwealth of Virginia.
4. Anthem is not contracting as the agent of the Association.
5. The policyholder acknowledges that it has not entered into this agreement based upon representations by any person other than Anthem or its agents and representatives and that no person, entity, or organization other than Anthem shall be held accountable or liable for any of Anthem's obligations created under this policy.
6. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this policy.

Y. Rate Stabilization Credit Program

During the term of this policy, Anthem may establish a rate stabilization credit program. Under this program, during the years of favorable claims experience the policyholder may receive a credit which may be used to offset future claims experience. The amount of the credit, if any, shall be established by Anthem at its sole discretion in accordance with its underwriting guidelines. The credit may be used by Anthem to stabilize future rate increases, but it may not be taken by the policyholder in the form of a refund. If the policyholder terminates coverage with Anthem, unused credit shall not be paid to the policyholder.

Z. The "BlueCard" Program for Covered Services Rendered Outside Anthem's Service Area

The provisions of the BlueCard Program do not apply to routine vision care benefits.

Anthem does business only within a certain geographic area in the Commonwealth of Virginia. Claims for covered services rendered outside of that geographic area may therefore be processed through a program called "BlueCard" before being presented to Anthem for payment. Anthem is able to participate in this program because it is a licensee of the Blue Cross and Blue Shield Association, which has developed policies, including network access rules, for the program. Under the BlueCard program:

- Anthem remains responsible for providing the insurance coverage for claims for covered services incurred outside its service area; but

- Other Blue Cross and/or Blue Shield companies (called “host companies”) provide such services as contracting and handling interactions with participating providers.

The financial terms of the BlueCard program are described in general terms below.

A covered person’s liability for a claim for covered services that is processed through BlueCard will be based on the lower of:

- The provider’s billed charges; or
- The negotiated price Anthem pays the host company.

These negotiated prices vary among host companies based on the terms of their provider contracts. A negotiated price may represent:

- The actual price paid on the claim to the provider by the host company; or
- An estimated or average price determined by the host company in accordance with BlueCard policies.

“Estimated price” means a price:

- Based on the actual price, but
- Adjusted by the host company to reflect expected aggregate payments to its providers, or to one or more particular providers. The expected aggregate payments include settlements, withholds, any other contingent payment arrangements, and non-claims transactions.

“Average price” means a price based on the host company’s average savings expected for all or a specified group of its providers, after settlements, withholds, any other contingent payment arrangements, and non-claims transactions. It may result in a greater variation from the actual price than an estimated price would.

Host companies using estimated or average prices will prospectively adjust them to correct for over- or underestimation of past prices. But the amount paid by the covered person is final and will not be affected by these adjustments.

In a few states, a covered person’s liability for a claim, for covered services, that is processed through BlueCard will be based on a price calculated according to a state-mandated method. For example, a state may require a host company to add a surcharge.

Under the BlueCard program, recoveries from a host company or its providers may arise in several ways, such as through:

- Anti-fraud and abuse audits;
- Provider or hospital audits;
- Credit balance audits;
- Utilization review refunds; and
- Unsolicited refunds.

A host company may engage a third party to assist in identifying and collecting these amounts. If so, the fees of the third party are netted against the recovery. The net recovery amounts are then applied according to BlueCard policies. These generally require correction on a claim-by-claim or prospective basis.

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01/01/2010

Date Created 4/23/10 8:39:46

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