Anthem

Richmond, Virginia

MEDICARE SUPPLEMENT POLICY
PLAN F

Anthem Blue Cross and Blue Shield, welcomes you as a Policyholder.

This booklet, any Endorsements and your application make up your Medicare supplement Policy. Your Policy is designed to help cover many of the expenses partially covered by Medicare. **READ YOUR POLICY CAREFULLY**.

When we use "we", "our", "us" or "Anthem", we mean Anthem Blue Cross and Blue Shield. When we use "you", "your", "yours" or "yourself", we mean Policyholder.

RENEWABILITY: This Policy is guaranteed renewable for your lifetime. We may not terminate this Policy for any reason other than the nonpayment of Premiums, fraudulent or material misrepresentation on your application.

PREMIUMS SUBJECT TO CHANGE: We may change the Premiums for this Policy at the same time we change the Premiums for all policies of your class and benefit plan. The Premiums will not change because of any change in your age or health status.

PRE-EXISTING CONDITION LIMITATION: This Policy does not provide benefits for losses you incur during the first six (6) months after the Policy Effective Date if caused by or resulting from a Pre-existing Condition.

You will receive credit toward this six (6) month period if you were insured under any Blue Cross and/or Blue Shield Policy or any type of Medicare supplement Policy on the day immediately before the Policy Effective Date. See the section of this Policy entitled "Prior Insurance Credit".

This Pre-existing Condition limitation does not apply if the Policy Effective Date is no more than six (6) months after your 65th birth date.

NOTICE OF 30-DAY RIGHT TO EXAMINE THE POLICY: If you decide you do not want this Policy, you may return it to us within 30 days after receiving it. If you return it, the Policy will be void from the Policy Effective Date. We will promptly refund the Premiums you paid minus any amounts paid in claims.

IMPORTANT NOTICE ABOUT STATEMENTS IN YOUR APPLICATION: Please read the attached copy of your application. This Policy was issued on the basis that the information entered on your application is correct and complete. You should write us immediately about any information shown on your application that is not correct or complete. Any incorrect or omitted statements could cause the denial of an otherwise valid claim.

NOTICE TO BUYER: This Policy may not cover all of your medical expenses.

We agree to provide you the benefits stated in this Policy. Benefits are subject to the provisions of this Policy and any Endorsements, and information on your application.

We issued this Policy in consideration of the application and payment of the Premium as provided by the Policy.

Policy Effective Date: This Policy begins at 12:01 a.m. Eastern Standard Time on the first day of the month following the month that we receive and accept your application for coverage.

This Policy is a legal contract between you and Anthem.

Anthem Blue Cross and Blue Shield

Terri A. Swanson
VP & GM Individual Medical, Senior Business

Table of Contents

Terms You Should Know

Capitalized terms in the Policy text mean the words have a specific meaning. This section defines these terms. If a defined term is used only in one Policy section, then that term is defined for you in the text where the term is used.

Benefit Period means the period, determined under Medicare, that starts the day you enter a Hospital as an Inpatient. It ends when you have been out of a Hospital or Facility for 60 days in a row (including the day of discharge). If you remain in a Facility, a Benefit Period ends when you have not received any skilled care at that Facility for 60 days in a row. A new Benefit Period starts the next time you enter a Hospital as an Inpatient after a Benefit Period ends.

Calendar Year means the period that starts January 1 and ends December 31 of each year. It also means part of a Calendar Year if the Policy Effective Date is other than January 1 or the Policy terminates before December 31. The first Calendar Year starts on the Policy Effective Date and ends on the earlier of the date the Policy terminates or December 31 of the same year. The last Calendar Year ends on the date the Policy terminates.

Coinsurance means the share of Medicare Eligible Expenses that you owe because Medicare pays such expenses at a rate less than 100%. Medicare sets the Coinsurance amounts each year.

Diagnosis Related Group (DRG) Amount means the flat-rate per Hospital discharge that Medicare Part A pays Participating Hospitals for Medicare covered Inpatient Hospital care rendered you. The basis of this rate is your diagnosis at the time of admission rather than your incurred Hospital costs. Participating Hospitals accept this amount as payment in full for Medicare covered Inpatient Hospital care.

Endorsement means a written change to your Policy that takes effect on a specific date.

Explanation of Medicare Benefits Notice (EOMB) means the notice that Medicare sends you after a Provider files a Medicare claim on your behalf. The EOMB explains the decision Medicare made on your claim. There are separate EOMB notices for Medicare Part A and Medicare Part B Medicare claim filings.

Facility — see Skilled Nursing Facility.

Hospital refers to an institution that provides care for which Medicare pays hospital benefits.

Immediate Relative means your:

- husband or wife.
- natural or adoptive parent, child, or sibling.
- stepparent, stepchild, stepbrother, or stepsister.
- father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law.
- grandparent or grandchild.
- spouse of grandparent or grandchild.

Injury means accidental bodily injury sustained by you as a direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while your insurance under this Policy is in force.

Inpatient means a patient who, upon Physician's orders, is admitted to a Hospital or Facility as a bed patient and is charged room and board for the care or treatment rendered.

Lifetime Reserve Days means the 60 days of Inpatient Hospital care available to you under Medicare Part A after you receive 90 days of Medicare covered Inpatient Hospital care in the same Benefit Period. You may use Reserve Days once during your lifetime.

Medicaid means "The Health Insurance for the Aged Act", Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare means "The Health Insurance for the Aged Act", Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare has two parts, Part A and Part B.

Part A of Medicare helps pay for:

- Inpatient care in a Hospital or Facility.
- home health care.
- hospice care.
- blood you receive as an Inpatient in a Hospital or Skilled Nursing Facility.

Most people do not pay Premiums for Part A of Medicare.

Part B of Medicare helps pay for:

- Physicians' services.
- Outpatient Hospital care.
- medical equipment.
- other medical services and supplies not covered by Medicare Part A.

Part B of Medicare has Premiums.

If you need more information about Medicare, you can get a copy of *The Medicare Handbook* from your local Social Security Administration Office.

Medicare-approved Charge means the amount that Part B of Medicare recognizes as reasonable for a covered service or supply.

Medicare Assignment means an arrangement where a Provider agrees to accept the Medicare-approved amount as the total charge for services and supplies covered by Part B.

Medicare Eligible Expenses means expenses covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

Medicare Part A Deductible means the amount of Medicare Eligible Expenses you must incur in each Benefit Period before Medicare Part A accepts any liability for all or part of the remaining Medicare Eligible Expenses. Medicare sets this deductible amount each year.

Medicare Part B Deductible means the amount of Medicare-approved Charges you must incur in each Calendar Year before Medicare Part B accepts any liability for all or part of the remaining Medicare-approved Charges. Medicare sets this deductible amount each year.

Physician means any of the following:

- Doctor of Medicine.
- Doctor of Osteopathy, licensed to practice medicine or perform surgery by the board of medical examiners of the state.
- Doctor of Podiatry.
- Doctor of Surgical Chiropody.
- Doctor of Chiropractic.
- Doctor of Dentistry.
- Doctor of Optometry.

A Physician must be duly licensed to practice in the state where he or she renders the services or supplies for which benefits are requested.

Policy means the agreement between you and Anthem. It includes your application, this Policy, and any Endorsements.

Policyholder means the person who signed the application and contracted for insurance under this Policy.

Policy Effective Date means 12:01 a.m. Eastern Standard Time on the first day of the month following the month we receive and accept your application for coverage.

Policy Year means the 12-month period that starts on the Policy Effective Date and each 12-month period after that. The last Policy Year ends on the date the Policy terminates.

Pre-existing Condition means a condition for which medical advice was given or treatment was recommended by or received from a Physician within six (6) months before the Policy Effective Date.

Premium means the amount of money you must pay for coverage under this Policy.

Provider means Physician, Skilled Nursing Facility, or any of the following Medicare-approved practitioners:

- Optician.
- Psychologist.
- Clinical Social Worker.
- Professional Counselor.
- Registered Physical Therapist.
- Audiologist.
- Speech Pathologist.
- Clinical Nurse Specialist in Psychiatric Mental Health.

Provider also includes any other Provider or supplier that Medicare authorizes to provide services or supplies. We cannot guarantee the availability of a particular Provider and are not responsible for any Provider's acts or omissions.

Service Area includes all of the Commonwealth of Virginia with the exception of the city of Fairfax, the town of Vienna or the area east of State Route 123. Contact us if you would like more information about our Service Area.

Sickness means illness or disease of the Policyholder which first manifests itself after the Policy Effective Date and while this Policy is in force.

Skilled Nursing Facility and Facility means a facility that participates in the Medicare program and provides skilled nursing care that is approved for payment by Medicare.

Anthem Blue Cross and Blue Shield. The mailing address is Anthem Blue Cross and Blue Shield, P. O. Box 27401, Richmond, Virginia 23279-7401.

United States means the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the territorial waters adjoining the land areas of the United States.

Who is Insured

This Policy insures you on the Policy Effective Date if, on that date, the required Premium is paid and you:

- will live in the Anthem Blue Cross and Blue Shield Service Area at least six months of the year; and
- are enrolled, or are eligible to enroll, under Part A or Part B of Medicare.

You are the only person this Policy insures.

When Your Insurance Starts

Your insurance under this Policy starts on the Policy Effective Date.

Privacy Protection and Your Authorization

1. Information may be collected from persons other than you so that we may determine the benefits to which you are entitled. The information often comes from medical care facilities and medical professionals who submit claims for you. Information is disclosed to others only as allowed by the Virginia Insurance Information and Privacy Protection Act. You have the right to see and correct all personal information which is collected about you. The term "personal information" is defined in the Act. A more detailed notice of our information practices is available upon request.

2. When you make application for coverage under this Policy, you agree that we may request from any source any medical information or other records when related to claims submitted to us for services you have received.

3. By accepting coverage under this Policy, you authorize any individual, association, firm, or corporation which has diagnosed your condition or rendered services to you to furnish us with necessary information and records or copies of records. This authorization extends to any person or organization in possession of any information or records related to the diagnosis, treatment, or services for your condition.

4. If we ask for information and do not receive it, payment for covered services cannot be made. The claim will be processed for payment only when the requested information or record has been received and reviewed.

Schedule of Benefits

This schedule describes the benefits for which you are eligible while insured under this Policy.

Basic Inpatient Hospital Benefits

If a Physician admits you to a Participating Hospital, this Policy pays:

- the Part A Medicare Eligible Expenses you incur up to the Medicare Part A Coinsurance amount for the 61st through the 90th day of care in any Benefit Period.
- the Part A Medicare Eligible Expenses you incur up to the Medicare Part A Coinsurance amount for each Lifetime Reserve Day you use.
- the Medicare Diagnosis Related Group (DRG) Amount for the Part A Medicare Eligible Expenses you incur for an additional 365 days of Inpatient Hospital care in your lifetime. These days are available only after you use all Medicare Inpatient Hospital coverage, including Lifetime Reserve Days.

Medicare Part A Deductible

If a Physician admits you to a Participating Hospital, this Policy pays the Medicare Part A deductible.

Blood Deductible

This Policy pays for the Medicare Parts A and B blood deductible for the first three (3) pints or units of blood, if applicable.

Basic Medical Care Benefits

This Policy pays for 20% of the Part B Medicare Eligible Expenses you incur for both Inpatient and Outpatient services or supplies, after the Medicare Part B Deductible is met.

Skilled Nursing Facility Care

If a Physician admits you to a Skilled Nursing Facility, this Policy pays the charges you incur up to the daily Medicare Part A Coinsurance amount for the 21st through 100th day of post-Hospital Skilled Nursing Facility care in a Benefit Period.

The Skilled Nursing Facility care that you receive must be:

- covered by Medicare; and
- provided by a Medicare participating Skilled Nursing Facility.

No benefits are payable after 100 days of Skilled Nursing Facility care in a Benefit Period.

Medicare Part B Deductible

This Policy pays the Medicare Part B Deductible.

One Hundred Percent (100%) of the Medicare Part B Excess Charges

This Policy pays 100% of the difference between the charge billed by the Provider and the Medicare-approved Charge. The total payment under Medicare and this Policy will not exceed any charge limitation set by Medicare or state law.

If no charge limitation is set by Medicare or state law for a particular service, the total payment for that service after combining benefits under Medicare and this Policy will not exceed the amount that would have been paid had the service had a charge limitation in effect when the service was rendered.

Medically Necessary Emergency Care in a Foreign Country

This Policy provides coverage to the extent not covered by Medicare for 80% of the charges for Medicare Eligible Expenses for medically necessary emergency Hospital, Physician, and medical care you receive outside the United States if:

- Medicare would cover such care when provided in the United States;
- such care begins during the first 60 consecutive days of each trip outside the United States;
- the trip begins after the Policy Effective Date; and
- your primary residence is in the United States.

This benefit is subject to a $250 Calendar Year deductible and a lifetime maximum of $50,000. If you elect to terminate this Policy and enroll in another Anthem Medicare supplement policy, deductible amounts, in whole or in part, will not transfer to the new Policy.

For this benefit, “emergency care” means care you need immediately because of an Injury or Sickness of sudden and unexpected onset.

A trip begins the day you leave the United States and ends the day you return.

Benefit Provisions

If Medicare Changes

The benefits provided under this Policy will change automatically in response to any changes in the amounts of any Medicare deductible or Coinsurance when specifically listed as a benefit in this Policy. The Premiums may change to correspond with such benefit changes.

If This Policy Changes

Any change made by us to this Policy that results in a reduction or elimination of your benefits or coverage, regardless of whether the change affects your Premium, will not be effective unless you agree to the change in writing. Additionally, any change made by us that increases your benefits or coverage and also results in an increase in your Premium will not be effective unless it is accepted by you in writing. However, any change in benefits that is required by law or regulation may be made by us without your written approval.

If Your Medicare Coverage Ends

If your coverage under Part A or Part B of Medicare ends while you remain entitled to Medicare, this Policy will pay benefits as if:

- You have coverage under both Part A and Part B of Medicare; and
- Medicare pays normal benefits.

If You Do Not Have Medicare Coverage

If you are eligible for, but do not have, coverage under Part A or Part B of Medicare, this Policy will pay benefits according to the standards of the Medicare program as if:

- you have coverage under both Part A and Part B of Medicare; and
- Medicare pays normal benefits.

Coverage that takes the place of Medicare

Regardless of other provisions of this Policy, if you are eligible for any federal program that pays in place of or works with Medicare to pay your benefits, we will pay your Provider the lesser of:

- what you owe your Provider after taking into account the federal program benefits; or
- what we would have paid under your Policy just as if there were no federal program involved. In this instance, the amount we pay will never be more than the federal program's approved charge.

In other words, you or your Provider will not profit financially from coverage that takes the place of Medicare. Examples of this type of coverage are Black Lung benefits and the United Mine Workers benefit plan.

Provider's Supervision

Services provided under this Policy are valid when they are performed by a Provider. Supplies provided under this Policy are valid when they are prescribed by a Provider.

Exclusions and Limitations

This Policy does not provide benefits for services or supplies that are:

1. received by you before the Policy Effective Date.

2. for or rendered during an Inpatient admission which began prior to the Policy Effective Date.

3. for losses you incur within the first six (6) months after the Policy Effective Date if caused by or resulting from a Pre-existing Condition, except as otherwise provided by this Policy.

4. payable under Medicare.

5. not Medicare Eligible Expenses, except as specifically covered by this Policy.

6. not reasonable and necessary under Medicare program standards for diagnosing or treating a Sickness or Injury or for restoring a bodily function.

7. in excess of what Medicare allows for mental illness.

8. expenses for which there is no charge or for which you have no legal obligation to pay in the absence of this or any similar coverage.

9. furnished by a federal Provider or other federal agency.

10. paid for directly or indirectly by a governmental entity. This exclusion does not apply to services provided to individuals through a Veterans Administration Hospital or military hospital except for services required as a result of war or an act of war. This exclusion also does not apply to persons eligible for medical assistance from Virginia's Department of Medical Assistance Services. The Department of Medical Assistance Services shall be the payor of last resort to the benefits in this Policy.

11. covered under workers' compensation or similar law, an automobile or liability insurance plan or Policy, or employer group health plan that is required by federal law to pay benefits primary to those of Medicare.

12. required as a result of war or an act of war.

13. for outpatient prescription drugs.

14. for routine physical exams and immunizations.

15. for custodial care.

16. personal comfort items.

17. for eye glasses and exams for their prescription, fitting, or changing.

18. for hearing aids and exams for their prescription, fitting, or changing.

19. for cosmetic surgery, except as required for the prompt repair of an accidental Injury or to improve the function of a malformed part of the body.

20. for care, treatment, filling, removal, or replacement of teeth or structures supporting the teeth.

21. for routine foot care, the treatment of subluxation of the foot, the treatment of flat foot conditions, or orthopedic shoes and other supportive devices for the feet.

22. provided by an Immediate Relative or member of your household.

Prior Insurance Credit

This Policy provides prior insurance credit to prevent the loss of coverage for a Pre-existing Condition upon the transfer of policies.

You will receive credit toward the Pre-existing Condition limitation of this Policy if you were insured by any other Blue Cross and/or Blue Shield Policy or any other Medicare supplement Policy on the day immediately preceding the Effective Date of this Policy, or if you become insured under this Policy within six (6) months after your 65th birth date.

Premium Provisions

Payment of Premiums

You must pay the first Premium for coverage under this Policy on or before the Policy Effective Date. You must pay the Premiums after the first Premium on or before the Premium due date.

You may pay the Premiums monthly, semiannually, or annually as selected by you on your application. We will provide you written notice of payment due. The notice shows the amount of your Premium and the Premium due date.

Premium payments are payable to:

Anthem Blue Cross and Blue Shield
P. O. Box 85101
Richmond, Virginia 23285-5101

Bank Draft Option

The bank draft program provides for the automatic deduction of your Premiums for this Policy from a checking account at your eligible bank, credit union, or savings and loan account, as long as your financial institution approves this transaction. The deductions are monthly. If you wish to participate in this program or you need more information about this program, please contact us.

Premium Rates

We charge the same Premium rates for all Medicare supplement policies of your class and benefit plan.

Premium Changes

The Premiums charged for coverage under this Policy may change if the Policy benefits increase or decrease due to changes in:

- applicable deductible and Coinsurance amounts set by Medicare.
- Medicare benefits.
- state or federal law or regulations.

Any Premium change will apply to all policies of your class and benefit plan issued by Anthem.

Any Premium change will occur on or after the effective date of the corresponding change in Policy benefits.

We will notify you in writing at least 30 days before the effective date of any Premium change.

Grace Period

This Policy has a 31-day grace period. This means that you have 31 days after the Premium due date to pay any Premium, except the first Premium. The Policy will stay in force until the end of the grace period unless it terminates under another Policy provision. Premiums are due for the period the Policy stays in force. If any Premium is unpaid at the end of the grace period, the Policy will terminate.

Policy Changes

We may change the provisions of this Policy after the Policy Effective Date by issuing you an Endorsement.

An Endorsement that reduces or eliminates benefits or coverage in the Policy will require your signed acceptance unless we issue such Endorsement to:

- fulfill a request in writing made by you.
- exercise a specifically reserved right under this Policy.
- reduce or eliminate benefits to avoid duplication of Medicare benefits.

An Endorsement that increases benefits or coverage in the Policy with a corresponding increase in Premium during the Policy Year will require your signed acceptance unless such increase is required by:

- the minimum Medicare supplement standards; or
- law or regulation.

If the Policy changes to correspond with a benefit change under Medicare, we will notify you in writing of the change no later than 30 days before the annual effective date of the benefit change under Medicare.

We will notify you in writing of all other Policy changes no later than 30 days before the effective date of the change.

No change in this Policy is valid unless approved in writing by an executive officer of Anthem. No agent may change this Policy or waive any of its provisions.

When This Policy Terminates

You may terminate this Policy on the last day of any calendar month by notifying us in writing at least thirty (30) days before the end of the selected calendar month.

We will terminate this Policy if any Premium after the first Premium is unpaid at the end of the grace period. In this case, we do not have to give notice of the termination.

We may terminate or take back this Policy immediately upon written notice at any time if there is fraudulent or material misrepresentation made by you on your application.

Policy Termination Date

This Policy will terminate at 12:01 a.m. Eastern Standard Time on the first to occur of:

- the last day of the calendar month in which you cease to be eligible for Part A and Part B of Medicare.
- the last day of the calendar month for which you requested the Policy to be terminated provided written notice was given at least 30 days before the end of the selected month.
- the end of the grace period.
- the date immediately following the day you die. We should receive written notification of death within thirty (30) days after the date of death.

We will refund any Premiums paid for coverage minus any claims paid after the termination date.

This Policy does not cover any services or supplies provided on or after the date the Policy terminates.

Reinstatement

This Policy will terminate if you do not pay a Premium by the end of the grace period. If we later accept that Premium, we may or may not agree to reinstate the Policy.

If we do not require an application for reinstatement, we will reinstate the Policy effective the day the late Premium is accepted.

If we require an application for reinstatement, we have 45 days after the receipt of the application to act. We will reinstate the Policy on its approval date unless we notify you in writing of its disapproval within the 45-day period.

After the Policy is reinstated, you and Anthem will have the same rights as existed on the day immediately before the Policy terminated. Such rights are subject to any provisions endorsed or attached to the reinstated Policy.

We will not apply any Premiums to a period that is more than 60 days before the reinstatement date.

Medicaid Entitlement

If you become entitled to Medicaid benefits, you may suspend your benefits and Premiums under this Policy for up to 24 months. You must send us a written request for this suspension within 90 days after the date of your Medicaid entitlement.

Upon receipt of such request, we will refund the Premiums you paid for coverage under this Policy after the date of your Medicaid entitlement. Such Premiums are subject to adjustment for claims paid for losses incurred after the date of your Medicaid entitlement.

We will reinstate this Policy as of the date your Medicaid entitlement ends if you:

- notify us in writing of the loss of your entitlement within 90 days after the date of such loss; and
- pay the Premiums due from the date of the loss of your entitlement.

If the Policy reinstatement date is six (6) or more months after the Policy Effective Date, the Pre-existing Condition limitation in this Policy will not apply. Otherwise, you and Anthem will have the same rights as existed under the Policy on the day immediately before the suspended period began.

The Premium charged for the reinstated Policy will be at least as favorable to you as the Premium that would have been charged had your coverage not been suspended.

Your Insurance Cards

When you receive Medicare covered services or supplies, you should always show your Medicare card and your Anthem Blue Cross and Blue Shield identification card.

Your Anthem Blue Cross and Blue Shield identification card shows your identification number. You should write this number on all correspondence to Anthem including your Premium payment checks. Also, you should have this number available when making a telephone inquiry.

How to File a Claim

We must receive a claim before benefits are payable under this Policy.

Electronic claims filing for your Policy is generally established within 60 days after the first manually filed claim, and then most claims will be filed for you automatically. Until electronic claims filing is established, you will have to file your claims manually.

You may need to file your own claim for special services or supplies that you receive. You should refer to this section of the Policy for specific claim filing requirements.

Medicare Covered Services and Supplies Received in Virginia

When you receive Medicare covered services or supplies in Virginia, the Provider of such services or supplies must submit your Medicare claim to the:

- Part A intermediary responsible for processing claims for Inpatient care or Outpatient Facility care; or
- Part B carrier responsible for processing medical claims.

You should request that your Medicare claim reflect your coverage under this Policy.

After the intermediary or carrier processes your claim, you will receive an *Explanation of Medicare Benefits Notice* (EOMB). This notice shows whether or not Medicare filed your claim with Anthem. You should examine this notice carefully.

If the EOMB shows that Medicare filed your claim with us, then you do not have to send in a claim yourself.

If the EOMB does not show that Medicare filed your claim with us, then you must send us:

- a copy of the EOMB with your Anthem identification number noted.

Medicare Covered Services and Supplies Received Outside Virginia

If you receive Medicare covered services or supplies in a state other than Virginia, the Provider of such services or supplies must submit your Medicare claim to the Medicare intermediary or carrier for that state.

After the out-of-state intermediary or carrier processes your claim, you will receive an EOMB. You must send us:

- a copy of the EOMB; and
- an itemized bill.

If You Do Not Have Medicare Coverage

If you receive services or supplies that Part A or Part B of Medicare would cover if you were enrolled under that Part of Medicare, you must send us:

- an EOMB showing no Part A or Part B coverage; and
- an itemized bill.

Expenses Not Covered by Medicare

This Policy covers some services that Medicare does not cover.

To receive benefits for such services, you must send us:

- a copy of the EOMB, if applicable, with your Anthem identification number; and
- an itemized bill.

We will decide in our sole discretion whether such services are medically necessary. This Policy will not cover services that are not medically necessary.

Emergency Care in a Foreign Country

To receive benefits under this Policy for emergency care in a foreign country, you must send us:

- an itemized bill written in the English language and signed by you; and
- the exchange rate of the foreign country's currency to U. S. dollars in effect on the date services were rendered, if the bill is not in U. S. dollars.

General Claim Information

Claim Forms

If this Policy requires you to submit a claim form when filing your own claim, you must use the proper claim form. You can get the proper claim form by writing us or calling the Customer Service Department at 1-800-451-0361. Roanoke area calls should be directed to 985-5115.

If you do not receive a claim form within 15 days after the date you request it, you can send us a written statement of the nature and extent of the loss for which claim is being made. We must receive this statement within the time limit stated in the "Time Limit for Filing Claims" paragraph of this section.

Where To Send Claims

You should send any claim information required under the "How to File a Claim" section of this Policy to:

Anthem Blue Cross and Blue Shield
P. O. Box 27401
Richmond, Virginia 23279-7401

It is important to include the identification number shown on your Anthem Blue Cross and Blue Shield identification card in the information that you submit.

Time Limit for Filing Claims

We request the required proof of claim within 90 days:

- after the date you receive a service or supply; or
- from the date on your EOMB. (EOMB is discussed under the "How to File a Claim" section of this Policy.)

If you do not give proof in the 90-day period, you must give it as soon as possible. In any event, you must give the required proof no later than 15 months after the end of the 90-day period unless you are legally unable to act.

This provision does not apply if your claim is filed for you automatically.

Adjustment of a Claim

In cases where Medicare either adjusts or takes back a Medicare Part A or Part B claim payment, we may take the same action for any payment made pursuant to this Policy.

Release of Information

When you accept this Policy, you agree that any Provider or entity may release to us any information needed to process a claim. We will not be liable for communication about your medical information.

Physical Examination

Anthem, at its expense, has the right to have you examined by a Physician or Provider as often as reasonably necessary while a claim is pending.

Legal Action

No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy. No legal action may be brought after three (3) years from the time written proof of loss is required to be given.

Anthem Blue Cross and Blue Shield Participating/Contracting Plan

The Anthem Blue Cross and Blue Shield Participating/Contracting Plan is a billing program between Providers and Anthem.

Providers who participate in this plan are called Anthem Blue Cross and Blue Shield Participating/Contracting Providers.

Such Providers may agree to accept payment directly from us whether or not they accept Medicare assignment.

This billing program provides you a convenient service if you choose to receive health care from an Anthem Blue Cross and Blue Shield Participating/Contracting Provider.

When Are Claims Paid

We will pay the benefits that are payable under this Policy as soon as we receive:

- a claim which has been filed for you automatically; or
- the required proof of claim filed by you.

Who Are Claims Paid To

We can pay the benefits under this Policy to you or your Provider. We cannot require that the services be rendered by a particular health care services Provider.

If the Provider accepts assignment with Medicare, we are required by federal law to make payment directly to the Provider. If the Provider does not accept assignment with Medicare, we may pay all or a portion of any indemnities provided for health care services to your Provider.

Benefits for emergency care in a foreign country are payable only to you in United States currency in an amount based on the bank transfer exchange rate in effect on the date that services were rendered.

Any benefits payable to you and unpaid at your death will be paid to your estate.

If you are deemed legally unable to act, we may pay any benefits due you to your legal representative. If we pay benefits in good faith to your legal representative, we shall not have to pay such benefits again.

For persons eligible for medical assistance in Virginia, the Department of Medical Assistance Services shall be the payor of last resort with regards to the benefits in this Policy.

Questions About Benefits or Claims

If you have questions about benefits or claims, contact the Customer Service Department. Be sure to give your Anthem Blue Cross and Blue Shield identification number.

Call toll-free, 1-800-451-0361 (in Roanoke, 985-5115), or write:

Anthem Blue Cross and Blue Shield
P. O. Box 27401
Richmond, Virginia 23279-7401

General Information

Entire Contract

This Policy, your application for coverage, and any Endorsements form the entire contract between you and Anthem.

Assignment

You may not transfer or assign your right to receive:

- payment under this Policy for services or supplies rendered you to any person or entity other than the Provider of such services or supplies.

- benefits under this Policy.

Misstatement of Facts

All statements you made when applying for this insurance are considered representations and not warranties. No statements by you will be used to reduce or deny a claim unless we give you, your beneficiary or personal representative a copy of your statements.

If relevant statements about you were not accurate:

- we will make a fair adjustment of Premium; and
- the correct information will be used to decide if and in what amounts insurance is valid.

Time Limit on Certain Defenses

After two (2) years from the Effective Date of this Policy, only fraudulent misstatements in your application will be used to void the Policy or deny any otherwise valid claim.

Conformity with Virginia Statutes

If this Policy conflicts with any laws of the Commonwealth of Virginia, the Policy is changed to meet the minimum requirements of such laws.

Limitation on Damages

In the event you or your representative sues Anthem or any of our directors, officers, or employees acting in his or her capacity as a director, officer, or employee, your damages shall be limited to the amount of your claim for benefits. The damages shall not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. In no event shall this Policy be interpreted so that punitive or indirect damages, legal fees, or damages for emotional distress or mental anguish are available.

Anthem's Continuing Rights

Sometimes we may not insist on your strict performance of all Policy terms. Failure to apply terms or conditions does not mean we waive or give up any future rights under this Policy. We may later require strict performance of these same Policy terms or conditions.

Anthem Blue Cross and Blue Shield as an Independent Corporation

By purchasing this Policy, you are agreeing to the following statements:

- this Policy is a contract only between you and Anthem;
- we are an independent corporation. We have a license from the Blue Cross and Blue Shield Association to use their Blue Cross and Blue Shield service marks in a specific service area (mainly Virginia); and
- we are not the agent of the Blue Cross and Blue Shield Association.

You are also agreeing that you bought this Policy based only on representations made by Anthem. Additionally, you are also agreeing that only we are liable for the obligations created by this Policy.

This provision does not create any additional Policy obligations for Anthem.

Incorrect Benefit Payment

Every effort is made to ensure claims are processed promptly and correctly. If payments are made on your behalf and we later find the payments were incorrect, you shall be required to repay any overpayment or incorrect payment to us. A written notification will be sent to you if a refund is requested. Future benefits may be reduced to recover overpayments or incorrect payments made under this Policy.

Third Party Beneficiaries

A Hospital, Skilled Nursing Facility, Provider, or any other supplier of goods or services will not benefit from this Policy. In other words, the Policy is an explanation of services and payments available to you. It is not intended for anyone else's benefit. As such, no one else may assert any rights based on your Policy.

Change of Name or Address

You should notify us in writing when your name or address changes. You should sign your notification of change.

We will mail your notices to the most recent address on file with us.

Change of State Residency

If you no longer reside in Virginia, this Policy will remain in effect. We will not change your Policy provisions or benefits. If you wish to transfer your coverage to a Medicare supplement policy offered by the Blue Cross and/or Blue Shield plan serving your new area of residence, we will help you with this transaction. Please be aware the policy offered by the other Blue Cross and/or Blue Shield plan may not be the same as this Policy in terms of cost and benefits.

Notice Requirements

Notice by Anthem to you is considered given if:

- hand-delivered; or
- mailed by United States mail, postage prepaid, and addressed as shown in our files.

Notice by you to Anthem is considered given if:

- hand-delivered;
- electronically sent on your behalf; or
- mailed by United States mail, postage prepaid, and addressed as follows:

  Anthem Blue Cross and Blue Shield
  P. O. Box 27401
  Richmond, Virginia 23279-7401

Such notice by you or by Anthem is considered given and effective as of the date delivered, electronically sent, or so deposited in the mail.

Important Information

If you need to contact someone about this Policy, please contact your agent or Anthem at:

Anthem Blue Cross and Blue Shield
P. O. Box 27401
Richmond, Virginia 23279-7401
1-800-451-0361
In Roanoke: 985-5115

If you have been unable to contact or obtain satisfaction from your agent or Anthem, you may contact the Virginia Bureau of Insurance at:

Bureau of Insurance
State Corporation Commission
P. O. Box 1157
Richmond, Virginia 23218
1-804-371-9691

Written correspondence is preferable so a record of your inquiry is maintained. When contacting your agent, Anthem or the Bureau of Insurance, have your Anthem Blue Cross and Blue Shield identification number available.