VISION BENEFIT BOOKLET

for

TRUSTEES OF INDIANA UNIVERSITY
GA

Administered by

Anthem BlueCross BlueShield

IMPORTANT: This is **NOT** an insured benefit plan. The benefits described in this booklet (or in any rider or amendments attached to) are funded by the employer. The employer is responsible for the payment of benefits. Anthem does not assume any financial risk or obligation with respect to claims.

Effective Date: 1/1/2017

Introduction

Welcome!

This *benefit booklet* (and any riders or amendments that may be attached) is a description of the benefits provided by the vision plan (the *plan*) that is offered by your *employer*. This *booklet* tells you important information about the vision care benefits you may receive while enrolled in this *plan*. This *booklet* will replace any older booklets that may have received previously.

Within this *booklet*, *members* are referred to as "you" or "your". Some words in this *booklet* will be italicized. These are words that have special meanings. See the Definitions section of this *booklet* to learn what those words mean.

Anthem Blue Cross and Blue Shield (Anthem) also known as the *claims administrator* (*administrator*), has been designated by your *employer* to provide administrative services for this *plan*. Administrative services include claims processing. The *administrator* has also arranged a network of vision care *providers* to service this *plan*.

Please review this *booklet* carefully so you know where to find the information that you may need. Store it in a convenient place. If you have questions about the benefits in this *booklet*, please contact your *employer* or the *administrator* at the number in the Contact Information section of this *booklet*.

Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross and Blue Shield Service Marks in portions of the State of Indiana Anthem has entered into a contract with the *employer* on its own behalf and not as the agent of the Association.

Contact Information

Administrator Information
Anthem Blue View Vision
Member Services
(866) 723-0515

Please send claims to:
Anthem Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111

Please send appeals to:
Anthem Blue View Vision
Attn: Appeals Department
555 Middle Creek Parkway
Colorado Springs, CO 80921

How to Get Language Assistance
Anthem employs a language line interpretation service for use by all Member Services call centers. Simply call the Member Services phone number on your ID card and a representative will be able to help you. Translation of written benefit materials, such as this booklet, can also be asked for by contacting the phone number on your ID card. TTY/TDD services are also available by dialing 711. A special operator will get in touch with us to help with your needs.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

Table of Contents

Schedule of Benefits

This Schedule of Benefits is a summary of the benefits available to you for *covered services* from *providers*. See the Covered Services section of this *booklet* for a more complete explanation of the vision services covered by this *plan*. All *covered services* are subject to the terms, conditions, limitations and exclusions of this *booklet*.

Choice of Vision Care Provider. Nothing in this *booklet* restricts or interferes with your right to select the vision care *provider* of your choice. However, your benefits may be reduced when you use a *non-network provider*.

Dependent Age Limit:	To the end of the month in which the child attains age 26.

Covered Service	Benefit Frequency	Network Copayment/Allowance	Non-Network Reimbursement
Routine Eye Exam	Once every calendar year	$20 copayment	Up to $42

Definitions

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

Actively at Work: Present and capable of carrying out the normal assigned job duties of your *employer*. *Subscribers* who are absent from work due to a health related disability, maternity leave or regularly scheduled vacation are still considered actively at work.

Additional Savings Program: A discount program included in this vision *plan*. It can be used with certain non-covered services and benefits for which you have exceeded the benefit frequency limits and maximums. The discount plan is subject to change at any time.

Administrative Services Agreement (agreement): The agreement between the *claims administrator* and the *employer* regarding the administration of certain elements of the benefits of this *plan*. The agreement consists of this *booklet*, the *employer's* application (if any), any amendments or riders attached, your *ID card*, and your application for enrollment. If there is any conflict between this *booklet* and the agreement, the agreement shall control.

Benefit Booklet (booklet): This booklet, which is the summary of the terms, conditions, limitations and exclusions of your vision benefits.

Calendar Year: A 12 month period beginning on January 1st in which benefit frequencies and maximums apply. See the Schedule of Benefits for frequencies and maximums.

Claims Administrator (administrator): The organization or entity that your *employer* has contracted with to provide administrative and claims payment services for this *plan*. The administrator does not assume any financial risk or obligation with respect to claims. The administrator for this plan is Anthem.

Copayment: A set dollar amount that you are responsible to pay for *covered services*. See the Schedule of Benefits for your copayment amounts.

Covered Service: A service, supply or treatment described in this *booklet* that is performed, prescribed, directed or authorized by a *provider*. A covered service is considered incurred on the date the service, supply or treatment was given to you. To be a covered service the service, supply or treatment must be:

- within the scope of the license of the *provider* performing the service;
- rendered while coverage under the *plan* is in force;
- within the *maximum allowable amount*
- not specifically excluded or limited by the *booklet*; and
- specifically included as a benefit within the *booklet*.

Dependent: A person of the *subscriber's* family who is eligible for coverage under this *plan* as described in the Eligibility and Enrollment section of this *booklet*.

Effective Date: The date your coverage begins under this *plan*.

Employer: the company, corporation, partnership or other entity that has entered into an *administrative services agreement* with the *administrator* to service this *plan*.

Family Coverage: Coverage for you (the *subscriber*) and your eligible *dependents*.

Fees: The periodic charges that the *employer* is required to pay to maintain benefits under this *plan*. You may be required to pay all or a portion of the fees. See your *employer* for more information on fees.

Identification Card (ID card): A card issued by the *plan* that identifies you and shows which plan you are covered under. Your ID card may also contain other important information about your coverage. You should carry this card with you and present it to your *provider* whenever you receive vision care.

Maximum Allowable Amount: The maximum amount that the *plan* will pay for *covered services*. See the section How Your Benefits Work for more information on how the maximum allowable amount is determined.

Member: A person that is enrolled under this *plan* (a *subscriber* or *dependent*).

Network Provider: A *provider* who has entered into an agreement with the *administrator* to service this *plan*. Network providers have agreed to accept the *plan's* payment, plus what you have to pay, as payment in full for *covered services*.

Non-Network Provider: A *provider* that has not entered into an agreement with the *administrator* to service this plan. Non-network providers can charge you for amounts that exceed the *plan's maximum allowable amount*.

Open Enrollment: A period of time determined by the *employer* during which you and/or your eligible family members may enroll for coverage under this *plan*. Open enrollment will be held at least once every year. See your *employer* for more information on open enrollment.

Plan: The group vision benefit plan provided by the *employer* and described in this *booklet*.

Provider: A duly licensed person or facility that has been approved by the *plan* and provides services within the scope of an applicable license

Subscriber: The employee that has enrolled for and been accepted for coverage under this *plan*.

Eligibility and Enrollment

You may have to satisfy certain requirements to participate in the *employer's* benefit plan. These requirements may include probationary or waiting periods, *actively at work* standards (as determined by the *employer)*, or state and/or federal law.

Who is Eligible

These eligibility requirements are described in general terms. For more specific eligibility information, see your human resources or benefits department. The following rules apply unless you are otherwise notified by the *employer*.

Subscriber. To be eligible to enroll as a *subscriber*, you must:

- be an employee, member of the *employer*;
- be entitled to participate in the *employer's* benefit plan;
- have satisfied any probationary or waiting period established by the *employer*;
- be *actively at work*; and
- meet the eligibility criteria stated in the *agreement*.

Dependents. The following persons are considered *dependents* when they are listed on the *subscriber's* enrollment form and meet all dependent eligibility criteria established by the *employer*:

- **Your Spouse**. Your spouse under a legally valid marriage.

- **Dependent Children.** Your or your spouse's children, including:
  - natural children, stepchildren, or newborn children;
  - legally adopted children or children for whom you or your spouse are the legal guardian or as otherwise required by law (the *administrator* may require that you complete a Dependency Affidavit and provide them with copies of any legal documents that award guardianship – temporary custody is not sufficient to establish eligibility under the *plan*);
  - children who the *employer* has determined are covered under a Qualified Medical Child Support Order as defined by any applicable state law.

  Coverage for dependent children will continue until the age limit stated in the Schedule of Benefits.

Newborn and Adopted Child Coverage. Your or your spouse's newborn will be covered for an initial period of 31 days from the date of birth. Your or your spouse's adopted child will also be covered for an initial period of 31 days for emergency coverage only. A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Coverage for newborns and adopted children will continue beyond the 31 days only if a request to add the child to this coverage has been submitted to the *administrator*. The request must be submitted within 31 days after the birth or adoption/placement of adoption of the child or within 10 days after the *administrator* provides the necessary form for you to complete, whichever is later.

Adding a Child due to Award of Legal Custody or Guardianship. If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage would start on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order. If you are required by a qualified medical child support order or court order, as defined by applicable state or federal law, to enroll your child under this coverage, you may enroll the child at any time without regard to any *open enrollment* limits. Coverage under this *plan* will be in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any dependent age limit listed in the Schedule of Benefits. Any claims payable under this *plan* will be paid, at the *plan's* discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. The *employer* will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to the *administrator* directly.

Enrollment

Initial Enrollment. When you first become eligible for coverage, you can enroll for single (*subscriber*) or family (*subscriber* and *dependents*) coverage. You must submit an application by the date stated in the *agreement* or according to the *plan's* underwriting rules for an initial application for enrollment.

If the *administrator* does not receive the initial application by the required date, you and your *dependents* will not be able to enroll for coverage until the next *open enrollment* period or during a special enrollment period, whichever is applicable. See the section Who is Eligible above or talk to your *employer* for information on eligibility requirements.

Open Enrollment Period. Open enrollment means a period of time (at least 31 days prior the Employer's renewal date and 31 days following) which is held no less frequently than once every year. If you or your *dependent* did not enroll for coverage during the initial enrollment period, you may apply for coverage at any time, but will not be enrolled until the *employer's* next *open enrollment* period.

Special Enrollment. If you did not enroll during the initial enrollment or during an *open enrollment* period, you may still be able to enroll in special situations. This is called special enrollment. Below tells you what situations may qualify you or your *dependents* for special enrollment.

- If you declined coverage for yourself or your *dependents* (including your spouse) because of other vision coverage, you may be able to enroll in this *plan* without waiting for the next *open enrollment* period. You must request enrollment within 31 days after the other coverage ends.

- If you have a new *dependent* as a result of marriage, birth, adoption, placement for adoption or other order of guardianship you may be able to enroll your *dependents* in the *plan*, provided that you request enrollment within 31 days of the event. See the section Newborn and Adopted Child Coverage above for more information on coverage for newborn or adopted children.

  In addition, if you have a new *dependent* as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself (the *subscriber*) and your *dependents*. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

- You and your *dependents* may also enroll under two additional circumstances:
  1. the *subscriber's* or *dependent's* Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, provided enrollment is requested with 60 days of the loss of coverage/eligibility; or
  2. the *subscriber* or *dependent* becomes eligible for a subsidy (state premium assistance program), provided enrollment is requested with 31 days of becoming eligible.

To request special enrollment or obtain more information, call the Member Services telephone number on your *ID card*, or contact your *employer*.

Effective Date of Coverage

Coverage under this *plan* begins on your *effective date*. Your *employer* may impose a waiting period before you are eligible to receive benefits under this *plan*. This waiting period will not exceed 90 days. To learn your specific *effective date* under this *plan* or to see if there is a waiting period, talk to your *employer*. You can also contact the *administrator* by calling the number located on the back of your *ID card* or by visiting their website at www.anthem.com, www.empire.com, www.bcbsga.com.

Notice of Changes

You are responsible to notify the *employer* of any changes which will affect your or your *dependents'* eligibility under this *plan*. Changes in eligibility include change in address, a marriage, divorce, death, gaining or losing a dependent, you become eligible for Medicare, or your enrollment in or loss of coverage from another plan. You must provide timely notice of changes according to the provisions in the Enrollment section above. Failure to provide notice of persons no longer eligible for services will not obligate the *plan* to pay for such services. Also, acceptance of payments for *fees* from the *employer* for persons no longer eligible for services will not obligate the *plan* to pay for such services.

When you notify your *employer* of changes in eligibility, the *employer* must then send notice to the *administrator*. All notifications by the *employer* must be in writing and on approved forms. Such notifications must include all information reasonably required to make the necessary changes.

A *member's* coverage terminates on the date such *member* ceases to be in a class of *members* eligible for coverage. The *plan* has the right to bill the *subscriber* for the cost of any services provided to such person during the period such person was not eligible under this *plan*.

Termination and Continuation

When Your Coverage Ends

You and your *dependents* will continue to be covered under this *plan* as long as you are employed by the *employer* and meet the necessary eligibility requirements. Your coverage will end if:

- your employment with the *employer* ends;
- you no longer meet the *employer* or the *plan's* eligibility requirements;
- the *plan* is discontinued;
- the *fees* for this plan fail to be paid.

In all cases, coverage will end at the expiration of the period for which the last contribution of *fees* were paid.

When Your Dependent Child's Coverage Ends.
Coverage of an enrolled child ceases at the end of the month when the child reaches the dependent age limit stated in the Schedule of Benefits. Coverage of a disabled child over age the dependent age limit will end if the child is found to be no longer totally or permanently disabled.

United States Military Reserve and National Guard. If you stop your coverage because you are called to active duty, then you may have you coverage reinstated once your active duty is over. Your coverage will be reinstated without any waiting periods. Contact your *employer* for information on how to restart your coverage once you end active duty.

COBRA Continuation of Coverage

COBRA continuation of coverage is available when your *employer's* coverage would otherwise end. COBRA allows you and your *dependents* to continue coverage for either 18, 29 or 36 months depending on the event.

COBRA coverage is available to you and your dependents for 18 months for the following events:

- You lose coverage due to a reduction in working hours, a layoff, or strike.
- You lose coverage because your employment ends (for voluntary or involuntary loss, except for gross misconduct).

COBRA coverage is available to you and your dependents for 29 months for the following events:

- You or your *dependent* was disabled when coverage ended or within 60 days after the coverage ended. However, you or your *dependent* must continue to be disabled after 18 months has passed. The Social Security Administration must determine if you are disabled.

COBRA coverage is available to your dependents for up to 36 months for the following events:

- Your death.
- You become eligible for Medicare in the 18 months before an event listed above.
- You divorce or separate from your spouse.
- Your dependent children no longer qualify as *dependents*.

You must notify your *employer* within 60 days if you or your *dependents* wish to continue coverage under COBRA after an event. Once notified, your *employer* will provide the information on how coverage under COBRA may continue, and must give the *administrator* notice within 30 days of the event that you wish to continue coverage. Contact your *employer* for more information.

How Continuation of Coverage Ends. Your continuation of coverage ends when the time period that you qualified for runs out. However, coverage may end before that time if one of the following occurs:

- The *agreement* between the *administrator* and the *employer* ends. If your *employer* switches coverage you will be able to continue coverage under their new plan.
- You or the *employer* fails to pay any applicable *fees*.
- You tell us in writing to cancel your coverage.
- The date your spouse remarries and becomes eligible under the new spouse's plan.

Coverage may also end for COBRA if the following occurs:

- You are eligible for coverage with another group plan. However, if your COBRA plan covers something that the other plan doesn't then you may continue coverage. Your coverage will continue until the group covers that exclusion or you are no longer eligible.
- You get Medicare
- Your coverage was extended to 29 months and you are now no longer disabled.

For More Information. This notice does not fully describe the continuation coverage or other rights under the *plan*. More information about continuation coverage and your rights under this *plan* is available from your *employer*.

For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website at www.dol.gov/ebsa.

How Your Benefits Work

This section tells you how this *plan* works, including information on *providers* and how the *plan* pays for your vision care, as well as more information on what you can expect for your out-of-pocket expenses.

> **IMPORTANT:** This is **NOT** an insured benefit plan. The benefits described in this *booklet* (or in any rider or amendments attached to) are funded by the *employer*. The *employer* is responsible for the payment of your benefits. Anthem is only the *administrator* and does not assume any financial risk or obligation with respect to claims.

Choosing a Provider

Please read the following information so you will know from whom or what group of *providers* vision care may be obtained.

Network Providers. This *plan* has a network of vision care *providers* for you to use. They are called *network providers*, because they have an agreement with the *administrator* to service this *plan*. They have agreed to provide *covered services* to you for a negotiated rate. *Covered services* received from a *network provider* is considered in-network care. You will have less out-of-pocket costs when you use a *network provider*.

Non-Network Providers. A *non-network provider* is a vision care *provider* that does not have an agreement with the *administrator* to service this *plan*. They have not agreed to the plan's negotiated rate for *covered services*. Using *a non-network provider* will typically increase your out-of-pocket costs. The *plan* will pay up to the *maximum allowable amount* for vision care received from a *non-network provider*. You will be responsible to pay for the difference between the *maximum allowable amount* and the *provider's* actual charge. Covered services you receive from *non-network providers* are considered out-of-network care.

> **Note:** Certain *covered services* may only be covered when received by a *network provider*. The *plan* will not pay for such services if they are received from a *non-network provider*. See the Schedule of Benefits to determine if any benefits in this *plan* are only covered in-network.

Maximum Allowable Amount

Payments for vision care to *network* and *non-network providers* is based on the *plan's maximum allowable amount*. This amount is the maximum amount the plan will pay for *covered services*. The amount is based on the *plan's* established network fee schedule. Your cost share will differ depending on your choice of vision care *provider*.

In-Network. For *covered services* received in-network, the *maximum allowable amount* is equal to the amount stated in the *network provider's* agreement for this *plan*. If the *network provider* charges less than the rate stated in the *provider's* agreement, the *provider* charge will be considered the *maximum allowable amount*.

Out-of-Network. For *covered services* received out-of-network, the *maximum allowable amount* is the lesser of the actual charge or the rate stated in the *plan's* network fee schedule. The *plan* will pay up to the reimbursement amount listed in the Schedule of Benefits for *non-network providers*. You are responsible to pay for any difference in the reimbursement amount and the *provider's* actual charge.

Your Cost Share Amount

You may be required to pay a part of the *maximum allowable amount* for *covered services*. This is called your cost share amount. *Copayments* are an example of a cost share amount. See the Schedule of Benefits for your cost share amount for *covered services*.

Your cost share amount may vary depending on whether your receive vision care from a *network* or *non-network provider*. You may have higher cost sharing amounts when using a *non-network provider*.

The *plan* will not pay for vision care that is not a *covered service*. You will have to pay all charges for services that are not covered. Vision care that is received after you have met any benefit maximums or allowances, or benefit frequency limits is considered not covered.

Benefit Maximums, Allowances, Reimbursements and Frequency Limits

The amount the *plan* pays for your benefits is subject to your benefit maximums, allowances, reimbursements and benefit frequency limits. We will not pay for vision care services that go over these amounts, or for services that are received more than the listed frequency limits. See the Schedule of Benefits for your maximums, allowances, reimbursements and frequency limits.

Covered Services

This section tells you what services are covered under this *plan*. All *covered services* are subject to the terms, conditions, limitation and exclusions whether they are received from a *network* or *non-network provider*. See the Schedule of Benefits for your cost share for these *covered services*.

Routine Eye Exam. This *plan* covers a complete eye exam with dilation as needed. The exam is used to check all aspects of your vision.

What Is Not Covered

This section tells you what items or services are not covered under this *plan*. These items are provided as an aid to identify certain common items that may be mistaken for *covered services*. This is not a complete listing. Only items listed in the section Covered Services are covered under this *plan*.

This plan will not pay for services incurred for, or in connection with, any of the items below:

- For services received from an individual or entity that is not a *provider*, as defined in this *booklet*.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a *member* receives the benefits in whole or in part. This exclusion also applies whether or not the *member* claims the benefits or compensation. It also applies whether or not the *member* recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which you have no legal obligation to pay in the absence of this or like coverage.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a *network provider*).
- Prescribed, ordered or referred by, or received from a member of your immediate family, including a spouse, child, brother, sister or parent.
- For the completion of claim forms or charges for health records or reports, unless otherwise required by law.
- For missed or cancelled appointments.
- Charges in excess of the *maximum allowed amount*.
- For services received prior to your *effective date*, or services received after this *plan's* termination date.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- For sunglasses and accompanying frames.
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care.
- For orthoptics or vision training, and any associated supplemental testing.
- For non-prescription lenses.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- For lost or broken lenses or frames, unless you have reached the benefit frequency period stated in the Schedule of Benefits.
- For services or supplies not specifically listed as covered in this *booklet*.
- For certain eyewear brands on which the manufacture imposes a no discount policy.
- For services or supplies combined with any other offer, coupon, or in-store promotion.
- For cosmetic lens options or other lens add-ons, except as stated in the Covered Services section of this *booklet*.

How to Submit a Claim

This section describes how you submit a claim and what information you should include on your claim. When you receive care from a *network provider*, the *provider* will typically submit the claim for you. However, if you receive care from a *non-network provider*, you will be responsible to file the claim.

Notice of Claim. After you receive vision care, you must contact the *administrator* to notify them of the claim. You should do this within 90 days from the date you received care. If you are not able to send the claim within 90 days, it will not void or reduce your claim. However, you must send notice as soon as reasonably possible, and in no event later than one year from the date it was due, unless you are legally incapacitated.

Claim Forms and Proof of Claim. Once you provide notice to the *administrator* of your claim, they will send a claim form to you within 15 days. The claim form will have instructions on how to fill it out and where to submit it.

If you do not receive the claim form the *administrator* sends, you may submit other proof of your claim, such as a copy of the itemized bill. The itemized bill should include the following information:

- the date of service;
- the patient's name, date of birth, and member ID number (found on your *ID card*);
- the type of service;
- from whom and where the service was received; and
- the patient's signature and the *provider's* signature.

If the information you submit to the *administrator* is not sufficient, they will send you a written notice that tells you what additional information is needed. If you do not provide this information, your claim may be denied.

Notice of claim, claim forms and copies of itemized bills can be sent to the following address:
Anthem Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111
Phone: (866) 723-0515

You will receive written notice telling you if your claim is approved or denied. If your claim is denied and you do not agree with the denial, you can appeal the claim decision. See the section How to Submit an Appeal for more information.

Explanation of Benefits. Once your claim is submitted to the *administrator*, you will often receive an explanation of benefits (EOB). The EOB is a summary of what this *plan* will pay for the *covered services* you received. The EOB is not a bill, but a statement from the *plan* to help you understand your benefits and out-of-pocket costs. The EOB will show:

- the total amount charged for the vision care you received;
- how much of the charges the *plan* is responsible to pay;
- how much of the charges you are responsible to pay;
- general information about your appeals rights.

General Provisions

Entire Contract, Changes. This *booklet*, the *agreement*, the *employer's* application, any riders or amendments, and your or your *dependent's* application, if any, makes up the entire agreement the plan and the *employer*. Any and all statements made by the *employer*, as well as any and all statements made to the *employer*, are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this *plan*, will be used in defense to a claim under the *plan*. No agent or employee of the *administrator* is authorized to change the form or content of this *booklet*. Changes can only be made through an amendment authorized and signed by an officer of the *employer*.

Modifications. This *booklet* allows the employer to make plan coverage available to its members. However, this *booklet* may be subject to amendment, modification and termination in accordance with any of its provisions, the *agreement*, or by mutual agreement between the *employer* and the *administrator* without the permission or involvement of any *member*. Changes will not be made effective until the date specified in the written notice sent by the *administrator* to the *employer* about the change. By electing vision coverage under this *plan*, or by accepting *plan* benefits, all *members* who are legally capable of entering into a contract, and the legal representatives of all *members* that are incapable of entering into a contract, agree to all terms, conditions and provisions of this *booklet*.

Circumstances Beyond Control of the Plan. In the event of circumstances beyond control of the *plan*, including, but not limited to, a major disaster, epidemic, complete or partial destruction of facilities, riot, or civil insurrection, the plan will make a good faith effort to arrange for an alternate method of providing coverage. In such event, the plan and *network providers* will provide services as is practical an according to their best judgment, but the plan and *network providers* will incur no liability or obligation for delay or failure to provide or arrange for services if such failure or delay is caused by such an event.

Coordination of Benefits. This *plan* is considered primary in all circumstances.

Right of Recovery. When the *plan* overpays a claim, it has the right to recover the overpayment. The *plan* may recover the overpayment from you, the person or *provider* we paid, or another plan.

Relationship of Parties – Plan and Network Providers. The relationship between the *plan* and *network providers* is an independent contractor relationship. *Network providers* are not agents or employees of the *plan*, nor is the *plan*, its employees or any employee or agent of the *network providers*.

Relationship of Parties – Employer, Member, and Plan. Neither the *employer* nor any *member* is the agent or representative of the *plan*. The *employer* is responsible for passing all information to the *member*. It is the *employer's* duty to notify the *plan* of eligibility information in a timely manner. The *plan* is not responsible for payment of *covered services* if the *employer* fails to provide the *plan* with timely notification of *member* eligibility or termination.

Not Liable for Provider Acts or Omissions. The *plan* is not responsible for any claim for damages arising out of, or in any manner connected with, any injuries suffered by a *member* while receiving care from any person, *provider* or in any *provider's* facility.

Transfer of Benefits. Only you (the *subscriber*) and your *dependents* as show on the *administrator's* records are entitled to this *plan's* benefits. These rights are forfeited if you or any of your *dependents*:

1. transfer those rights; or
2. aid any person in fraudulently obtaining plan benefits.

You and/or your *dependents* must reimburse the *plan* for any benefits paid in this context.

Conformity with Law. Any provision of this *booklet* which is in conflict with federal law is hereby automatically amended to confirm to the minimum requirements of such laws.

Legal Actions. No action at law or in equity shall be brought to recover on this *plan* prior to the expiration of 60 days after written proof of claim has been furnished in accordance with the requirements of this *plan*. No such action shall be brought after the expiration of three (3) years after the time written proof of claim is required to be furnished. You must exhaust the *plan's* appeals procure before filing a lawsuit or other legal action of any kind against the *plan*.

Vision Services. The *plan* does not provide *covered services* to *members*, but merely pays for them. You shall have no claim against the *plan* for acts or omissions of any *provider* from whom you receive *covered services*. The *plan* has no responsibility for a *provider's* failure or refusal to provide you with *covered services*.

Statements and Forms. *Subscribers* or other applicants for coverage will complete and submit applications, questionnaires or other forms/statements the *plan* may reasonable need. Applicants understand that all rights to benefits under the *plan* are dependent on all information provided being true, correct and complete. Any material misrepresentation by a *member* may result in termination of coverage. The *administrator* will not use statements made by a *member* to void this coverage after it has been in effect for two (2) years. However, this does not apply to fraudulent misstatements.

Delivery of Documents. The *administrator* will provide and *ID card* for each *member* and a *benefit booklet* for each *subscriber*.

Reservation of Discretionary Authority. The *administrator* shall have all powers necessary or appropriate to enable it to carry out its duties in connection with the administration of the *plan* and the interpretation of this *booklet*. This includes, without limitation, the power to construe the *agreement* to determine all questions arising under the *plan*, to resolve *member* appeals and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation of the *booklet* of the *plan*. A specific limitation or exclusion will override more general benefit language. The *administrator* has complete discretion to interpret the *booklet*. The *administrator's* determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are covered. The *administrator's* decision shall not be overturned unless determined to be arbitrary and capricious. However, a *member* may utilize all applicable *member* appeal procedures.

Contracting Entity. The *employer* acknowledges its understanding that the *agreement* constitutes a contract solely between the employer and Anthem. Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, which is an association of independent Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits Anthem to use the Blue Cross and Blue Shield Service Mark. Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association. This paragraph does not create any additional obligations whatsoever on our part other than those obligations created under other provisions of the *plan*.

How to File an Appeal

This section tells you what to do when you have questions, suggestions, concerns, or complaints. The plan's Member Services representatives are specially trained to answer your questions about your vision benefits. Please call the number provided in the Contact Information section near the front of this *booklet* or on your *ID card* with questions regarding:

- Your coverage and benefit levels, including copays or reimbursement amounts; or
- Specific services or claims you have received.

You will be notified in writing if a claim or other request for benefits is denied in whole or in part. If your claim is denied, the notice of denial will explain why your claim was denied and will describe your rights under this appeals procedure. A complaint procedure also is in place to help you understand the decisions in your claims.

Complaint Procedure

The complaint procedure is a resource that provides reasonable, informative responses to complaints that you may have about the *plan*. A complaint is an expression of dissatisfaction that can often be resolved by an explanation of the terms and conditions of your *plan*. Please contact the *plan* with any concerns that you may have about the decision in your claim or your coverage and benefit levels.

If you have a complaint or problem concerning benefits or services, you should contact Member Services. You may submit your complaint by letter or by telephone. You are encouraged to file your complaint within 60 days of the initial, adverse action, but must file no later than six months after the initial action. The time required to review complaints does not extend the time in which the appeal must be filed.

Appeals Procedure

An appeal is a formal request from you asking the *plan* to change its decision of a claim or benefit determination. If you are notified in writing that your claim was denied, or for any other adverse decision by the *plan*, you will be advised of your right to an internal appeal.

The appeals process may be initiated by you, your authorized representative, or a *provider* acting on your behalf. You are encouraged to submit the appeal within 60 days after you receive the written notice that your claim was denied, but no later than within six months. The request should include any information or documents you feel would be important in the decision of your appeal. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of any documents, records or other information relevant to your appeal.

The individuals responsible for reviewing your appeal will not be the same individuals who made the initial decision in your claim or benefit determination. Nor will they be the subordinates of the initial decisions makers and no deference will be given to the initial denial. Within a reasonable period of time, but no later than 30 days after the *plan* receives your written or oral request for an appeal, we will send you or your authorized representative a written decision.

Your request for an internal appeal must be submitted to the following address or telephone number:

Anthem Blue View Vision
Attention: Appeals Department
555 Middle Creek Parkway
Colorado Springs, CO 80921
Phone: (866) 723-0515

Authorized Representatives. If you would like to designate an authorized representative to submit an appeal on your behalf, the *plan* must receive your request in writing. Contact Member Services for more information on how to designate an authorized representative. You do not need to send a notice if your *provider* is submitting the appeal on your behalf.

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 Identification 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, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. 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.

Get Help In Your Language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in Your language for free. Call the Member Services number on Your Identification Card for help. (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 Member Services telephone number on the back of Your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD: 711).

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa
Ǹ ɓéɖé dyí-ɓèɖèìn-ɖèɔ ɓé m̀ ké bɔ̌ nìà kɛ kè gbo-kpá- kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Ɖá méɓà jè gbo-gmɔ Kpòè nɔɓà nìà nì Dyí-dyoìn-bɛ̃̀ɔ̃ kɔ̃ɛ ɓé m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali
আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।(TTY/TDD: 711)

Burmese
ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရရှိင်ခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။ (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dinka
Yin nɔŋ yic ba ye lëk në yök ku bë yi kuɔny në thöŋ yin jäm ke cin wëu töu kë piiny. Cɔl rän töŋ dë kɔc kë luɔi në nämba dën tö në I.D kat du yic. (TTY/TDD: 711)

Dutch
U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstennummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d’identification. (TTY/TDD: 711)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati
તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano
Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian
Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao
ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ
ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ໂທຫາເບີໂທຂອງຜ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo
Bee ná ahoot’i’ táá ni nizaad k’ehjí niká á a’doowol t’áá jíík’e. Naaltsoos bee atah nílínígíí bee néého’dólzingo nanitinígíí béésh bee hane’í bikáá’ áaji’ hodíílnih. Naaltsoos bee atah nílínígíí bee néého’dólzingo nanitinígíí béésh bee hane’í bikáá’ áají’ hodíílnih. (TTY/TDD: 711)

Nepali
तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch
Du hoscht die Recht selle Information un Helfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Helfe aa. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe
Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian
Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apelați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan
E iai lou ‘aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian
Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu
ۃپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔(TTY/TDD:711)۔

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish
רופט די איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם.
מעמבער באדינונגען נומער אויף אייער קארטל פאר הילף (TTY/TDD:711)

Yoruba
O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)