Vision Certificate of Coverage

Blue View Vision

EX.A.20

INDIANA UNIVERSITY SHIP

Anthem Insurance Companies, Inc.
220 Virginia Ave
Indianapolis, Indiana 46204

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Welcome!

Thank you for choosing Anthem Blue Cross and Blue Shield (Anthem) for your vision care coverage. The following materials make up your plan:

- this booklet;
- your application, if any; and
- any endorsements or riders.

Your employer (also referred to as your *group*) has the following documents which are part of the terms of your *plan*:

- the *group contract*; and
- the group master application.

This *certificate* contains important information such as what vision care services are covered and how they will be covered. It replaces any older certificates issued to you for this vision plan.

Within this *certificate members* are referred to as “you” or “your”. Anthem is referred to as “we,” “us” or “our.” All italicized words have special meanings that are defined in the Definitions section of this *certificate*.

Please review this *certificate* so you know where to find the information that you may need. Store it in a convenient place and refer to it whenever you have questions about your vision care coverage. See the section Contact Us for information on important phone numbers, addresses and websites.

Questions regarding your policy or coverage should be directed to:

Anthem Blue Cross and Blue Shield

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

Contact Us

If you have questions about your coverage or need assistance finding a Blue View Vision *network provider*, please contact us.

For Customer Service
Anthem Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111
(866) 723-0515

Visit us on-line
www.anthem.com

Hours of Operation
Monday – Saturday
8:30 a.m. to 11:00 p.m. Eastern Time

Sunday
11:00 a.m. to 8:00 p.m. Eastern Time

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Schedule of Benefits

This schedule is an outline of your benefits. You need to refer to the entire *certificate* for complete information about the benefits, conditions, limitations and exclusions of your *plan*.

CHOICE OF VISION CARE PROVIDER: Nothing contained in this *certificate* restricts or interferes with your right to select the vision care provider of your choice, but your benefits are reduced when you use a *non-network provider*. See the section How Your Benefits Work for more information.

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network Providers	Non-Network Providers
Routine Eye Exam Limited to one exam Once Every Benefit Period	$20 Copay	Reimbursed Up To $42

Laser Vision Correction Services
Participating LASIK/ photorefractive keratectomy (PRK) surgical centers offer a discounted rate for *members* enrolled under this *plan*.

Note: Benefit limits are combined In Network and Out of Network for all services covered on this *plan*.

Eligibility and Enrollment

Who is Eligible
This section will tell you who is eligible to enroll for coverage, as well as when you can enroll for coverage.

Subscriber. You are eligible to be a subscriber and have coverage under this *plan* if you are an employee or other member of the *group* and meet the *group's* eligibility criteria. See your *group* for more information on specific eligibility requirements.

Dependents. You may enroll your eligible *dependents* for coverage under this *plan*. Your *dependents* are only eligible for coverage if they are one of the following:

- Spouse: Your spouse under a legally valid marriage.
- Domestic partner: Your domestic partner under a legally registered and valid domestic partnership. Check with your *group's* human resources or benefits department to see if your domestic partner is eligible for coverage under this *plan*.
- Children: Your or your spouse's or domestic partner's child by blood or by law up to age 26. This includes your natural children, stepchildren, legally adopted children, children placed for adoption, foster children or children for whom you are the legal guardian or have been court-ordered to provide coverage.

  Your children may continue coverage beyond the above stated age limit if:
  - they are unmarried and incapable of self-support due to an intellectual disability or physical handicap;
  - are financially dependent on you or your spouse or domestic partner for support and maintenance; and
  - were enrolled and disabled prior to reaching the limiting age of this *plan*.

  You and the child's physician must fill out a disabled dependent form and provide it to us. Contact us to obtain the form. After two years from when you initially provided proof, we may ask for continued proof of the child's disability, but no more than once a year.

Newborn and Adopted Child Coverage. You or your spouse's or domestic partner's newborn or adopted children will be covered for an initial period of 31 days from the date of birth, placement for adoption, or adoption. For an adopted child, the date of adoption is the date you assume or retain a legal obligation to support the child. If you want your newborn or adopted child to continue coverage beyond this time, you must contact your *group* within 31 days of the date of birth, placement for adoption, or adoption to add them to this plan.

Enrollment

Initial Enrollment. Your *group* will have an initial enrollment period for newly eligible employees and their dependents to enroll for coverage. You may need to meet a waiting period established by the *group* before you can enroll for coverage. See your *group's* human resources or benefits department to determine if there are any waiting periods.

If you or your *dependents* do not enroll during the initial enrollment period you will only be able to enroll during an open enrollment or special enrollment period. Keep reading for more information on open and special enrollment periods.

Open Enrollment. At least once a year your *group* will hold an open enrollment period. During the open enrollment period you and your *dependent*s can enroll for coverage. If you do not enroll during the open enrollment period, you may have to wait until the next open enrollment period, unless you qualify for a special enrollment period. See below for more information on special enrollment.

Special Enrollment. Your plan elections chosen during initial or open enrollment are intended to remain the same until the next open enrollment period. However, there may be times when you or your *dependent*s can enroll for coverage outside of the open enrollment period. This is allowed if you have certain qualifying events that happen. Qualifying events are:

- You or your *dependents* did not previously enroll for coverage because you had coverage under another group plan (including COBRA or other continuation coverage) and have since become ineligible for that plan. You must request enrollment within 31 days of this qualifying event.
- You have a change in the number of *dependents* due to marriage, birth, adoption, court order, legal guardianship, or death. You must request enrollment within 31 days of this qualifying event.

- You or your *dependents* lost coverage under Medicaid or a Children's Health Insurance Program (CHIP), or became eligible for a subsidy (state premium assistance program) under Medicaid or CHIP. You must request enrollment within 60 days of this qualifying event.

Notice of Changes in Eligibility. You must tell your *group* if there are any changes that will affect your or your *dependent*'s eligibility. This includes a change in address or a change in the number of your *dependents*. The *group* is then responsible to notify us of any changes according to the terms of the *group contract*. If your *group* fails to notify us of your changes in eligibility, it does not obligate us to pay for your vision care.

Your Effective Date. Your coverage begins at 12:01 a.m. Eastern Time on the *effective date*. Your *effective date* and enrollment requirements are described in the *group contract*. See your *group's* human resources or benefits department for more information on your specific *effective date* under this *plan*.

Statements and Forms. *Subscribers* or applicants for membership shall complete and submit applications, questionnaires or other forms or statements the *plan* may reasonably request. Applicants for membership understand that all rights to benefits under this *certificate* are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a *member* may result in termination of coverage as provided in the Termination and Continuation of Coverage section. We will not use a statement made by a *member* to terminate the *member's* contract after two years have passed since the enrollment date. This does not apply, however, to fraudulent misstatements.

Delivery of Documents. We will provide an identification card and a *certificate* for each *subscriber.*

Termination and Continuation Of Coverage

Except as otherwise provided, your coverage will terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your *group's* agreement with us and your specific circumstances, such as whether premium has been paid in full:

If Your Group Cancels Coverage. Your coverage will end if your group cancels coverage or on the date the *group contract* between us and the *group* ends.

If You Cancel Your Coverage. If you want to cancel your or your *dependent's* coverage you need to notify your *group*. See your *group's* human resources or benefits department for more information on how to cancel your coverage. If you cancel, your *group* will be responsible to notify us in writing of the cancellation.

If You or Your Dependents Are No Longer Eligible. Coverage will end when you and/or your *dependents* no longer meet the eligibility requirements as outlined under the section Eligibility and Enrollment. When you or your *dependents* are no longer eligible, the date coverage ends is determined by the *group* in accordance with its eligibility requirements.

Fraud, Intentional Misrepresentation, Misuse of an ID Card. We will cancel this coverage if you or the *group* participates in any kind of intentional misrepresentation of material fact (knowingly provide false information) or fraud during the application and/or enrollment process. Subject to the incontestability provision, we will cancel this coverage if you or the *group* participates in any kind of intentional misrepresentation of material fact (knowingly provide false information) or fraud during the application and/or enrollment process. We may also cancel your coverage for other types of fraud, such as if you allow any other person to use your ID card to obtain benefits, or if you use another *member's* ID card (including one of your *dependent's* ID card) to obtain benefits. You will be held liable for any payments we make as a result of fraud. For any fraud or intentional misrepresentation, coverage will end on the date we send the written notice of cancellation.

If Your Group Does Not Pay the Premium. We must receive the premium no later than the end of the grace period for your coverage to remain in force. If your *group* does not pay your premium by the end of the grace period as stated in the *group* contract, we may cancel this coverage.

If You Fail to Pay the Premium. If you fail to pay or fail to make satisfactory arrangements with the *group* to pay your portion of the premium, coverage will end as of the last date for which premium was paid.

We Cease to Offer This Coverage. If we cease to offer coverage in the group market, we will cancel your coverage in accordance with the terms and conditions of state laws.

Continuation of Coverage

COBRA Continuation of Coverage. Your employer is subject to COBRA if they have more than 20 employees. 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 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 us 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 *group contract* between us and the employer ends. If your employer switches coverage you will be able to continue coverage under their new plan.
- You fail to pay the premium (subject to the grace period).
- 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. However, if your COBRA plan covers something that the other group 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.

How Your Benefits Work

This section tells you how we set the payment amount for *covered services*. It will also tell you more about what you pay out-of-pocket for *covered services*, as well as how your choice of *provider* may affect your out-of-pocket costs. The portion you must pay for *covered services* is stated in the Schedule of Benefits at the beginning of this *certificate*.

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

> **Important Note:** We do not restrict or interfere with your right to select the *provider* of your choice, but your benefits are reduced when you use a *provider* who is not a *network provider*.

Network Providers**.** We have a network of vision care providers for you to use. We call them network providers, because they have agreed to take part in our Blue View Vision network. They have agreed to provide *covered services* to you for a negotiated rate. *Covered services* you receive from a network provider are considered In-Network care.

> **IMPORTANT:** If you opt to receive optometric services or procedures that are NOT covered services under this plan, a network provider may charge you his or her usual and customary rate for such services or should provide you with a treatment plan that includes each anticipated service or procedure to be given. Prior to providing you with optometric services or procedures that are not covered services, the provider should provide you with the estimated cost of each service or procedure. To fully understand your coverage, you may wish to review your *certificate*.

Non-Network Providers. Non-network providers are vision care providers that did not agree to participate in our Blue View Vision network. They have not agreed to a negotiated rate and do not have a provider contract with us. Using a non-network provider will typically increase your out of pocket costs. *Covered services* you receive from non-network providers are considered Out-of-Network care.

Please call us or visit our website listed in the Contact Us section for help in finding a *network provider*.

Benefit Maximums, Allowances and Frequency Limits
The amount we pay for your benefits is subject to your benefit maximums, allowances and frequency limits. We will not pay for vision care services that go over your benefit maximums or allowances, or for services that are received more than the allowed frequency limits. Benefit maximums, allowances, and frequency limits are stated in the Schedule of Benefits at the beginning of this *certificate*.

Your Cost Share Requirements
We will pay up to the *maximum allowable amount* for *covered services*. You may be required to pay a part of the *maximum allowable amount*. This is called your cost share amount. *Copayments* are an example of a cost share amount. See the Schedule of Benefits to help determine your cost share amount for *covered services*.

Your cost share amount may vary depending on whether you receive vision care from a *network* or *non-network provider*. You may be required to pay higher cost sharing amounts when using *non-network providers*.

We will not pay for vision care that is not covered under this *plan*. You are required to pay all charges for vision care that is not covered. Vision care received after you have met any benefit maximums or benefit frequency limits are also not covered.

Covered Services

This section describes the *covered services* available under your vision care benefits when received by a *provider*. All *covered services* are subject to the exclusions listed in the Exclusions section and all other conditions and limitations of the *certificate*. The amount payable for *covered services* varies depending on whether you receive your care from a *network provider* or *a non-network provider* and the type of services and whether or not you choose optional services and/or custom materials rather than standard services and supplies. Payment amounts are specified in the Schedule of Benefits.

Routine Eye Exam. Your *plan* covers a comprehensive eye exam with dilation as needed. The exam is used to check all aspects of your vision. An eye exam does not include a contact lens fitting fee. Your plan covers a refraction in conjunction with an eye exam. A refraction is your prescription based on your eye exam. *Network providers* should not bill the refraction separately from the routine exam.

Additional Options. Benefits are available for additional services in accordance with the Additional Savings Program. For additional information on available discounts, please contact your *network provider* or call the member services number on your ID card.

Exclusions

We will not pay for services incurred for, or in connection with, any of the items below.

- **Not specifically listed**. Services not listed in the Covered Services section of this *certificate*.
- **Sunglasses**. Sunglass lenses or accompanying frames.
- **Excess amounts**. Any amounts in excess of the maximum benefits stated in this *certificate*.
- **Premium contact lenses fittings**. This includes fittings for more complex applications, including toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable lenses. It also includes extended/overnight wear lenses.
- **Cosmetic Options**. Cosmetic lens options not specifically listed in the Schedule of Benefits or the *covered services* section of this *certificate*. This includes non-prescription eyewear and lenses, plano lenses or lenses that have no refractive power.
- **Eye surgery**. Any diagnostic testing or medical or surgical treatment of the eyes, including any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and/or astigmatism. We also will not cover any contact lenses or eyeglasses required as a result of this surgery.
- **Lost or broken lenses or frames**. Any lost or broken lenses or frames, unless you have reached a new *benefit period*.
- **Experimental or investigative**. Any experimental or investigative services or materials.
- **Uninsured**. Services received before your *effective date* or after your coverage ends.
- **Voluntary payment**. Services for which you are not legally obligated to pay, for which you are not charged, or for which no charge is made in the absence of insurance coverage.
- **Work-related**. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation law or similar law, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those condition pursuant to any workers' compensation law or similar law, we will provide the benefits of this plan for such condition, subject to our right to a lien or other recovery applicable law.
- **Government treatment**. Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.
- **Non-licensed vision care providers**. Treatment or services rendered by non-licensed providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed vision care provider under the supervision of a licensed physician or licensed vision care provider, except as specifically provided or arranged by us.
- **Services of relatives**. Professional services or supplies received from a person who lives in your home or who is related to you by blood or marriage.
- **Hospital care**. Inpatient or outpatient hospital vision care.
- **Orthoptics**. Orthoptics or vision training and any associated supplemental testing.
- **Missed or Cancelled Appointments**. We will not pay for appointments a *member* has missed or cancelled.
- **Services or Supplies Combined with Discounts.** We will not pay for services or supplies when combined with any other offer, coupons or in-store advertisement. We will also not pay for certain brands of frames where the manufacturer does not allow discounts.

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*, you do not need to file a claim. The *network provider* will do this for you. However, if you receive vision care from a *non-network provider*, you will need to submit a claim to us.

Notice of Claim. After you receive vision care you will need to contact us, either by phone or mail (see contact information listed below). You should contact us within 20 days of the date you received vision care so we can provide to you claim forms for filing. Notice given by someone on your behalf, or to any agent authorized by us, within information to identify you will be deemed notice to us. If you are unable to contact us within 20 days, it does not mean we will not pay for your claim. Just contact us as soon as reasonably possible.

Claim Forms. We will provide claim forms within 15 days after you notify us. The claim form will have instructions on how to fill it out and where to submit. If you do not receive the claim form within 15 days of your notice, you may send us other written proof of your loss instead, such as an itemized bill from your *provider,* and you shall be deemed to have complied with the requirements of the *plan* as to proof of loss. To make it easier to process your claim, the other proof of loss should include the following:

- the date of service
- the patient's name, date of birth, and identification number
- the type and place of service
- your signature and the provider's signature

Proof of Loss. Your written proof of loss as described above should be provided to us within 90 days after the date of you received vision care. If it is not reasonably possible to provide your written proof of loss within this time, we will not invalidate or reduce your claim. However, you must send it as soon as reasonably possible, and in no event later than a year from when it was due, unless you are legally incapacitated.

Notice of claim, claim forms and other proof of loss can be sent to the following address:

Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111
Phone: (866) 723-0515

Time of Payment of Claims. We will pay claims immediately once we receive written proof of your claim, but not later than 30 days after we receive your proper written proof of loss.

Payment of Claims. We will pay claims directly to *providers* if they have an assignment of benefits on file. If the *provider* does not have an assignment of benefits on file then we will pay claims to you. If you pass away, we will pay claims to your designated beneficiary or to your estate if there is no assignment of benefits.

General Provisions

Entire Contract. The law of the state in which the *group contract* was issued will apply unless otherwise stated herein.

Entire Contract – Changes. Your plan is the entire contract of insurance. Your *plan* is made up of this *certificate*, your application (if any), and any amendments. In addition, your *group* has the *group contract* and the group master application, which are also a part of your *plan*. No agent of the plan is authorized to change the form or content of this plan or waive any of its provisions. Any changes to the *plan* must be endorsed by an executive officer. All statements made by you or your *group* shall be deemed representations and not warranties. No written statement made by you will be used in any context to deny a claim unless a copy of the statement is furnished to you, your beneficiary or personal representative.

Incontestability. The validity of this *plan* will not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue. No statement made by you or your *dependents* relating to you or your *dependent's* insurability will be used to contest the validity of this *certificate* unless the statement is contained in a written instrument signed by your or your *dependents*.

Physical Examinations. We may have you examined as reasonably needed while we are deciding to pay a claim.We may have you examined, at our expense, as reasonably needed while we are deciding to pay a claim.

Change of Beneficiary. You have the right to choose your own beneficiary.

Independent Contractors. *Providers* are not our agents or employees. They do not have the ability to waive or alter your *plan*. We are not responsible for any damages or injuries as a result of receiving care from any provider.

Right of Recovery. When we overpay a claim, we have the right to recover our overpayment. We may recover our overpayment from you, the person we paid, or another plan. We may deduct any overpayment from pending or future claims.

Benefits not Transferable. You are the only person able to receive benefits under this *plan*. You are not able to transfer your benefits to anyone else.

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 loss has been furnished in accordance with the requirements of this *plan*. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Coordination of Benefits. We consider this *plan* primary in all circumstances.

Grace Period. Your *group* is responsible to pay premiums on your behalf. After the first premium payment, your *group* has a grace period of 31 days to pay any *premium* due. During the grace period, your coverage will continue in force unless your *group* has given us written notice to cancel the coverage in accordance with the terms of the *group contract*. Your *group* is responsible to pay any premium to the plan. However, you may be required to pay a portion of the premium to your *group*. See your *group* for more information on premiums.

Conformity with the Law. Any provision of this *plan* which is in conflict with the laws of the state in which the *group contract* is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Modifications. We may change this *plan*, including the premiums, at any time by providing notice to the *group* at least 30 days before the change takes effect.

Notice of Privacy Practices. We maintain a privacy program designed to protect your health information consistent with applicable law. In addition to various laws governing your privacy, we have our own privacy policies and procedures in place that are designed to protect your information. We are required by law to provide individuals with notice of our legal duties and privacy practices. To obtain a copy of this notice, call us or visit the website listed in the Contact Us section of this *certificate*.

Value-Added Programs and Services. From time to time, we may offer or provide you with access to discount and/or value-added programs and services. In addition, we may arrange for third-party service providers such as dentists, optometrists, physicians, laboratories, or other health care professionals to provide you with discounts on goods and services. Although we may arrange for third parties to offer discounts on these goods and services, these discounts

and/or value-added programs and services are not insured benefits under this *certificate*. The third-party providers are solely responsible for providing the goods and/or services. We are not responsible for any goods and/or services nor are we liable if vendors refuse to honor such discounts. Further, we are not liable for the negligent provision of such goods and/or services by third-party providers. Discount and/or value-added programs and services may be discontinued at any time with or without advance notice. Discount and/or value-added programs and services may not be available in all areas or to people who opt out of marketing communications, or where otherwise restricted by regulation or law.

Reservation of Discretionary Authority

The following provision only applies where the interpretation of this *certificate* is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq. The *plan*, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, has complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are covered. However, a *member* may utilize all applicable grievance and appeals procedures.

The *plan*, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of the *certificate*. This includes, without limitation, the power to construe the *group contract*, to determine all questions arising under the *certificate*, to resolve member grievances and appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this *certificate*. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the *group contract* the *certificate*, provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Complaints and Appeals

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint. During those times, please contact our Customer Service Department. This section explains and offers instructions on what to do if you have a complaint or request.

Complaints
We provide quality member satisfaction services through our customer service center. All of our customer service representatives are responsible for addressing your concerns in a manner that is accurate, courteous, respectful and prompt. They are available to:

- answer questions you have about your benefits, our network of *providers*, information about claims, and our policies and procedures;
- make sure your suggestions are brought to the attention of appropriate person; and
- provide assistance to you when you want to file an appeal.

Please have your identification number (found on your ID card) handy when you contact customer service. We use this number to locate your important records with the least amount of inconvenience to you.

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

Appeals
If you do not agree with a claim denial made by us, you have a right to a full and fair review. A coverage denial means our determination that a service, treatment, drug or device is specifically limited or excluded under this *plan*.

You must submit your appeal to us in writing within 180 days from the date you received our claim denial notification. In support of your appeal, you may submit written comments, documents, records, or other information you think is relevant. Send your appeal to:

Blue View Vision
PO Box 9304
Minneapolis, MN 55440-9304
Phone: (866) 723-0515

Upon request and without charge, you will be provided reasonable access to and copies of all documents, records and other information relevant to or considered in our initial claim denial.

The person reviewing your appeal will not be the same person(s) who made the initial claim denial, nor will they be a subordinate or supervisor of the person(s) who made the initial claim denial. The person reviewing will also have appropriate medical and professional expertise and credentials to make a determination on your appeal. We will notify you of our determination in your appeal within 30 days upon receipt.

If you are not satisfied with the determination of your appeal, you may submit a second level appeal. The second level appeal must be submitted in writing within 180 days of the notice of our determination in the first appeal. You do not have to re-send the information that you submitted for your first appeal, but you are encouraged to submit any additional information that you think is important for review. We will notify you of our determination in your second level appeal within 30 days upon receipt.

Authorized Representative
You may authorize another person to represent you and with whom you want us to communicate regarding any specific claims or appeals. No authorization is required for treating provider to make a claim or appeal on your behalf. To authorize another person to represent you, contact our customer service department via the phone number listed in the Contact Us section. You can revoke the authorized representative at any time. You can authorize only one person as your representative at a time.

Statement of ERISA Rights

As a member of this plan, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA generally does not apply to church plans or to governmental plans, such as plans sponsored by city, county, or statement governments, or public school systems. Check with your *group* to determine if your plan is subject to ERISA.

As part of your rights, you may examine, without charge, at your *group's* plan administrator's office or at other specified locations, all plan documents. These include insurance contracts, copies of all documents filed by the plan with the Department of Labor (such as detailed annual reports) and plan descriptions. You may obtain copies of all plan documents and other plan information by writing to your *group's* plan administrator. The administrator may make a reasonable charge for the copies.

Plan Fiduciaries. In addition to creating rights for plan members, ERISA imposes duties upon the people who are responsible for the operation of your employee benefit plan. The people who operate your plan are called "fiduciaries" of the plan. They have a duty to operate the plan prudently and in the interest of you and other plan members.

- No one may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
- If your claim for a welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial.
- You have the right to have the plan administrator review and reconsider your claim.

Enforcement of ERISA Rights. Under ERISA, there are steps to enforce the rights listed above. For instance:

- If you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials (unless the materials were not sent because of reasons beyond the control of the administrator).
- If you have a claim for benefits for an appeal of a coverage decision, which is denied or ignored, in whole or in part, you may file suit in a state of federal court.
- If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court decides who pays court costs and legal fees.

If you are successful, the court may order the person you have sued to pay the court costs and fees. If you lose, the court may order you to pay these costs and fees. You may lose if, for example, the court finds your claim to be frivolous.

Assistance. If you have questions about your plan, contract your *group*. If you have questions about this statement about your rights under ERISA, contact the nearest Area Office of the Employee Benefits Security Administration, Department of Labor. You can find the contact information in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Definitions

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

Allowance. A dollar amount available to apply towards a material or service.

Benefit Period. A 12-month period in which benefits are tracked. You must wait until the benefit period interval in which you can receive *covered services*, as listed in the Schedule of Benefits. See your *group* to find out when the benefit period for this *plan* begins and ends.

Certificate. This summary of the terms of your benefits. It is attached to and is a part of the *group contract* and is subject to the terms of the *group contract*.

Copayment (or copay). A specific dollar amount indicated in the Schedule of Benefits for which you are responsible to pay.

Covered Services. Services and supplies or treatment as described in the *certificate* which are performed, prescribed, directed or authorized by a *provider*. A *covered service* is incurred on the date the service, supply or treatment was provided 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 this *certificate* is in force;
- Within the *maximum allowable amount*;
- Not specifically excluded or limited by the *certificate*;
- Specifically included as a benefit within the *certificate*.

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

Effective Date. The date when your coverage begins under this *certificate*.

Group. The employer that has entered into a *group contract* with us to provide the benefits of the *plan***.**

Group Contract. The contract issued by us to the *group* as a means of providing certain benefits to the *group's* employees and eligible *dependents*.

Maximum Allowable Amount. The maximum amount allowed for *covered services* you receive based on the fee schedule. The maximum allowable amount is subject to any copayments, coinsurance, limitations or exclusions listed in this *certificate*.

For a *network provider*, the maximum allowable amount is equal to the amount that constitutes payment in full under the *network provider's* participation agreement for this product. If a *network provider* accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the maximum allowable amount.

For a *non-network provider* who is a physician or other non-facility *provider*, even if the *provider* has a participation agreement with us for another product, the maximum allowable amount is the lesser of the actual charge or the standard rate under the participation agreement used with *network providers* for this plan.

The maximum allowable amount is reduced by any penalties for which a *provider* is responsible as a result of its agreement with us.

Member. A *subscriber* or *dependent* who has satisfied the eligibility conditions; applied for coverage; been accepted by us for coverage; and for whom premium payment has been made. *Members* are sometimes called "you" and "your."

Network Provider. A *provider* who has entered into a contractual agreement or is otherwise engaged by us to provide *covered services* and certain administration functions for the network associated with this *plan*.

Non-Network Provider. A *provider* who has not entered into a contractual agreement with us for the network associated with this *plan*.

Plan. The entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this *certificate*, your application (if any), any endorsements, the *group contract,* and the group master application.

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

Subscriber. The employee or other member of the *group* that has enrolled and been accepted for coverage under this *plan*.

Get Help in Your Language

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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