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*NAMIC Group Insurance Trust*

**For more information, visit our web site at [anthem.com](http://anthem.com)  
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**BVVI1586**

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Underwritten by Anthem Insurance Companies, Inc.



*Underwritten by Anthem Insurance Companies, Inc.*

# Your Vision Certificate



# Vision Certificate of Coverage

(herein called the "Certificate")

## Blue View Vision

Anthem Insurance Companies, Inc.  
120 Monument Circle  
Indianapolis, Indiana 46204

## CERTIFICATE

Welcome to Anthem Blue Cross and Blue Shield! This Certificate has been prepared by Us to help explain your vision care benefits. Please refer to this Certificate whenever you require vision services. It describes how to access vision care, what vision services are covered by Us, and what portion of the vision care costs you will be required to pay.

The coverage described in this Certificate is subject in every respect to the provisions of the Group Contract issued to the Group. The Group Contract and this Certificate and any amendments or riders attached to the same, shall constitute the Group Contract under which Covered Services and supplies are provided by Us.

This Certificate should be read in its entirety. Since many of the provisions of this Certificate are interrelated, you should read the entire Certificate to get a full understanding of your coverage.


Many words used in the Certificate have special meanings. These words appear in capitals and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. The Certificate also contains exclusions.

This Vision Certificate supersedes and replaces any Vision Certificate previously issued to you under the provisions of the Group Contract.

**Read your Certificate Carefully.** The Certificate sets forth many of the rights and obligations between you and the Plan. Payment of benefits is subject to the provisions, limitations and exclusions of your Certificate. It is therefore important that you read your Certificate.

### How to Obtain Language Assistance

We are committed to communicating with Our Members about their health plan, regardless of their language. We employ a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.



**President**

**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](http://www.in.gov/idoi).

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# 1 SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the amount of benefits available when you receive Covered Services from a Provider. Please refer to the **Covered Services** section for a more complete explanation of the specific vision services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of the Certificate including any attachments or riders.

**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.

## DEPENDENT AGE LIMIT

To the end of the month in which the child attains age 26

## COVERED SERVICES

## COPAYMENT/MAXIMUMS

### Exam

**Network**  
\$10 Copayment

**Non-Network**  
Reimbursed up to \$42

Limited to one exam per Member every 12 months.\*

**Prescription Lenses** (including factory scratch coating polycarbonate lenses for children under 19 years old and Photochromic lenses for children under 19 years old.) \$25 Copayment

### Basic Lenses (Pair)

- Single Vision Lenses
- Bifocal Lenses
- Trifocal Lenses

Reimbursed up to \$40  
Reimbursed up to \$60  
Reimbursed up to \$80

Limited to one set of lenses per Member every 12 months\*

**Frames** (Limited to one set of frames per Member every 24 months \*) \$0 Copayment Any Reimbursed up to \$45  
frame up to \$150 retail

## Prescription Contact Lenses

(traditional or disposable)

- Non-Elective Contact Lenses** (Availability once every 12 months \*)
 

\$0 Copayment	Non-Elective Contact Lenses are Reimbursed up to \$210
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- Elective Contact Lenses**

\$0 Copayment	Elective Contact Lenses are Reimbursed up to \$105
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(Availability once every 12 months\*)

**Note:** If you chose covered Non-Elective Contact Lenses or Elective Contact Lenses, no benefits will be available for covered eyeglass lenses and frames in that period.

\* from the Last Date of Service.

**Laser Vision Correction Services**

Participating Lasik/photorefractive keratectomy PRK surgical centers offer a discounted rate for Members enrolled under this plan. You are responsible for any remaining charges.

## 2 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 capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

**Actively at Work** - Present and capable of carrying out the normal assigned job duties of the Group. Subscribers who are absent from work due to a health related disability, maternity leave or regularly scheduled vacation will be considered Actively At Work.

**Additional Savings Program** – A discount program included in the vision benefit program. It can be used with certain non-covered services and plan overages. The discount plan is subject to change at any time.

**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.

**Coinsurance** - A percentage of the Maximum Allowable Amount for which you are responsible to pay. Your Coinsurance will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

**Copayment** - A specific dollar amount indicated in the Schedule of Benefits for which you are responsible.

**Covered Services** - Services and supplies or treatment as described in the Certificate which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service, the services, 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.

A Covered Service is incurred on the date the service, supply or treatment was provided to you.

**Dependent** - A Subscriber's spouse and dependent children who have met Our eligibility requirements and have not reached the age limit shown in the Schedule of Benefits.

**Effective Date** - The date when your coverage begins under this Certificate. A Dependent's coverage begins on the Effective Date of the sponsoring Subscriber.

**Elective Contact Lenses** - All prescription contact Lenses that are cosmetic in nature or Non-Elective Contact Lenses.

**Eligible Person** - A person who satisfies the Group's eligibility requirements and is entitled to apply to be a Subscriber.

**Enrollment Date** - The first day of coverage or, if there is a waiting period, the first day of the waiting period (typically the date employment begins).

**Family Coverage** - Coverage for the Subscriber and eligible Dependents.

**Group** - The employer or other entity or trust that has entered into a Group Contract with the Plan.

**Group Contract (or Contract)** - The contract between the Plan and the Group. It includes this Certificate, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

**Identification Card** - A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

**Last Date of Service** - The period of time in which benefits are tracked. The Member must

wait until the specific interval from the last date of service to receive Covered Services as listed in the Schedule of Benefits.

**Late Enrollee** - An Eligible Person whose enrollment did not occur on the earliest date that coverage can become effective under this Certificate, and who did not qualify for Special Enrollment.

**Lenses** - Materials prescribed for the visual welfare of the patient. Materials would include single vision, bifocal, trifocal or other more complex lenses.

**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 Product.

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 approved by the Plan; 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 Certificate.

**Non-Elective Contact Lenses** - Contact

Lenses which are provided for reasons that are not cosmetic in nature. Non-Elective Contact Lenses are Covered Services when the following conditions have been identified or diagnosed:

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

**Non-Network Provider** - A Provider who has not entered into a contractual agreement with Us for the Network associated with this Certificate.

**Open Enrollment** – A period of enrollment designated by the Plan in which Eligible Persons or their Dependents can enroll without penalty after the initial enrollment; see the Eligibility and Enrollment section for more information.

**Plan (or We, Us, Our)** – Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield which provides benefits to Members for the Covered Services that are described in this Certificate.

**Premium** - The periodic charges that the Member or the Group must pay the Plan to maintain coverage.

**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** - An eligible employee or Member of the Group who is eligible to receive benefits under the Group Contract.

### 3 ELIGIBILITY AND ENROLLMENT

You have coverage provided under this Certificate because of your employment with/membership with/ retirement from the Group. You must satisfy certain requirements to participate in the Group's benefit plan. These requirements may include probationary or waiting periods and Actively At Work standards as determined by the Group or state and/or federal law and approved by Us.

**Your Eligibility requirements are described in general terms below. For more specific eligibility information, see your Human Resources or Benefits Department.**

#### Eligibility

The following eligibility rules apply unless you are notified by Us and the Group.

#### Subscriber

To be eligible to enroll as a Subscriber, an individual must:

- Be either: An employee, Member, or retiree of the Group, and;
- Be entitled to participate in the benefit plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and be Actively At Work;
- Meet the eligibility criteria stated in the Group Contract.

#### Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by

the Subscriber, meet all Dependent eligibility criteria established by the Group and be:

- The Subscriber's spouse. For information on spousal eligibility please contact the Group.
- The Subscriber's or the Subscriber's spouse's natural children, newborn and legally adopted children, stepchildren, children for whom the Subscriber or the Subscriber's spouse is a legal guardian, or children who the Group has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.
- The following children, if the Subscriber provides more than fifty percent (50%) of the child's total support: the Subscriber's or the Subscriber's spouse's grandchildren or other blood relatives.

All enrolled eligible, children will continue to be covered until the age limit listed in the Schedule of Benefits.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves due to mental, intellectual, or physical disability. The Dependent's disability must start before the end of the period they would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must notify Us if the Dependent's status changes and they are no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

To obtain coverage for children, We may require that the Subscriber complete a "Dependency Affidavit" and provide Us with a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under this Certificate.

Coverage Effective Dates and enrollment requirements are described in the Group Contract.

## College Student Medical Leave

The Plan will extend coverage for up to one year when a college student otherwise would lose eligibility, if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

**Medically Necessary change in student status.** The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status). The Plan must receive written certification from the child's Physician confirming the serious illness or injury and the Medical Necessity of the leave or change in status.

## Enrollment

### Initial Enrollment

An Eligible Person can enroll for Single or Family Coverage by submitting an application to the Plan. The application must be received by the date stated on the Group Contract or the Plan's underwriting rules for initial application for enrollment. If We do not receive the initial application by this date, the Eligible Person can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, which ever is applicable.

If a person qualifies as a Dependent but does not enroll when the Eligible Person first applies for enrollment, the Dependent can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, which ever is applicable.

It is important for you to know which family members are eligible to apply for benefits under Family Coverage. See the section on eligible Dependents.

## **Newborn and Adopted Child Coverage**

Any Dependent child born while the Subscriber or Member's spouse is eligible for coverage will be covered from birth for a period of 31 days. Any Dependent child adopted while the Subscriber or the Member's spouse is eligible for coverage will be covered from the date of placement for purposes of adoption for a period of 31 days.

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, and will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

To continue coverage beyond the 31 day period after the child's birth or adoption you must notify Us by submitting a Change of Status Form to add the child under the Subscriber's Certificate. The Change of Status Form must be submitted within 31 days after the birth or placement of the child. If timely notice is given, an additional Premium for the coverage of the newborn child or adopted child will not be charged for the duration of the notice period. However, if timely notice is not given, We may charge an additional Premium from the child's date of birth or placement for adoption. Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure We have accurate records and are able to cover your claims.

If the child is not enrolled within 31 days of the date of birth or placement for adoption, coverage will cease.

## **Adding a Child due to Award of Legal Custody or Guardianship**

If a Subscriber or the Subscriber's 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. If We do not receive an application within the 31-day period, the child will be treated

as a Late Enrollee.

## **Qualified Medical Child Support Order**

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child under this Certificate, We will permit your child to enroll at any time without regard to any Open Enrollment limits and shall provide the benefits of this Certificate 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 Certificate will be paid, at Our 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. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

## **Special Enrollment/Special Enrollees**

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your other coverage ends (or within 60 days after Medicaid coverage ends) after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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 and your Dependents in the Plan, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If We receive an application to add your Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, that

person is only eligible for coverage as a Late Enrollee. Application forms are available from the Plan.

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program) under Medicaid or CHIP.

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If We receive an application to add your Dependent or an Eligible Person and Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, that person is only eligible for coverage as a Late Enrollee.

Application forms are available from the Plan.

### **Late Enrollees**

You are considered a Late Enrollee if you are an Eligible Person or Dependent who did not request enrollment for coverage:

- During the initial enrollment period; or
- During a Special Enrollment period; or
- As a newly eligible Dependent who failed to qualify during the Special Enrollment period and did not enroll within 31 days of the date you were first entitled to enroll.

You may apply for coverage at any time during the year as a Late Enrollee. However, you will not be enrolled for coverage with the Plan until the next Open Enrollment Period.

### **Open Enrollment Period**

An Eligible Person or Dependent who did not request enrollment for coverage during the initial

enrollment period, or during a Special Enrollment period, may apply for coverage at any time, however, will not be enrolled until the Group's next annual enrollment.

Open Enrollment means a period of time (at least 31 days prior the Group's renewal date and 31 days following) which is held no less frequently than once in any 12 consecutive months.

### **Notice of Changes**

The Subscriber is responsible to notify the Group of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Certificate. The Plan must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another vision plan. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of payments from the Group for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 31 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications by the Group must be in writing and on approved forms. Such notifications must include all information reasonably required to effect 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 the Subscriber's coverage.



### **Nondiscrimination**

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

### **Effective Date of Coverage**

For information on your specific Effective Date of Coverage under this Certificate, please see your human resources or benefits department. You can also contact Us by calling the number located on the back of your Identification (ID) Card or by visiting [www.anthem.com](http://www.anthem.com).

### **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 "Changes in Coverage: Termination, Continuation & Conversion" section.

### **Delivery of Documents**

We will provide an Identification Card for each Member and a Certificate for each Subscriber.

### **Contestability**

Your policy shall not be contested except for nonpayment of premium, after it has been in force for two (2) years from its date of issue; and no statement made by a person shall be used in contesting the validity of the insurance unless it is contained in a written instrument signed by the person making such statement.

## **4 TERMINATION, CONTINUATION AND CONVERSION**

### **Termination**

Except as otherwise provided, your coverage may 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 you terminate your coverage, termination will generally be effective on the last day of the billing period in which We received your notice of termination.
- Subject to any applicable continuation or conversion requirements, if you cease to meet eligibility requirements as outlined in this Certificate, your coverage generally will terminate on the last day of the billing period. The Group and/or you must notify

Us immediately if you cease to meet the eligibility requirements. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

- If you engage in fraudulent conduct or furnish Us fraudulent or misleading material information relating to claims or application for coverage, then We may terminate your coverage. Termination is generally effective 31 days after Our notice of termination is mailed, except when indicated otherwise in the Schedule of Benefits. We will also terminate your Dependent's coverage, generally effective on the date your coverage is terminated. We will notify the Group in the event We terminate you and your Dependent's coverage.
- A Dependent's coverage will generally

terminate the last day of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent, except when indicated otherwise in the Schedule of Benefits.

- If coverage is through an association, coverage will generally terminate on the date membership in the association ends.
- If you elect coverage under another carrier's vision benefit plan or under any other non-Anthem plan which is offered by, through, or in connection with the Group as an option instead of this Certificate, then coverage for you and your Dependents will generally terminate at the end of the billing period for which Premium has been paid, subject to the consent of the Group. The Group agrees to immediately notify Us that you have elected coverage elsewhere.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice to the Group. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for services received through such misuse.

## Removal of Members

Upon written request through the Group, a Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

## Reinstatement

You will not be reinstated automatically if coverage is terminated. Re-application is necessary, unless termination resulted from inadvertent clerical error. No additions or terminations of membership will be processed during the time you or the Group's request for

reinstatement is being considered by Us. Your coverage shall not be adversely affected due to the Group's clerical error. However, the Group is liable to Us if We incur financial loss as a result of the Group's clerical error.

## Continuation

### Federal Continuation of Coverage (COBRA)

The following applies if you are covered under a Group which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health plan. It can also become available to other Members of your family, who are covered under the Group's health plan, when they would otherwise lose their health coverage. For additional information about your rights and obligations under federal law under the coverage provided by the Group's health plan, you should contact the Group.

### COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Group's health plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Group's health plan is lost because of the qualifying event. Under the Group's health plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Group for Premium payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group's health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group's health plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Group's health plan because any of the following qualifying events happens:

- The parent-Subscriber dies;
- The parent-Subscriber's hours of employment are reduced;
- The parent-Subscriber's employment ends for any reason other than his or her gross misconduct;
- The parent-Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Group's health plan as a "Dependent child."

### **If Your Group Offers Retirement Coverage**

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Group, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Group's health plan, the retired Subscriber will become a qualified beneficiary with respect to the bankruptcy. The retired Subscriber's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under Group's health plan.

### **When is COBRA Coverage Available**

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), then the Group will notify the COBRA Administrator (e.g., Human Resources, external vendor) of the qualifying event.

### **You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

### **How is COBRA Coverage Provided**

Once the Group receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Subscribers may elect COBRA continuation coverage on behalf of

their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

### **How Long Will Continuation Coverage Last?**

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued only for up to a total of 18 months. In the case of losses of coverage due to the Subscriber's death, divorce or legal separation, the Subscriber's becoming entitled to Medicare benefits or a Dependent child ceasing to be a Dependent under the terms of the Group's health plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement.

### **How Can You Extend the Length of COBRA Continuation Coverage?**

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Group of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

- **Disability**

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. You must provide the SSA determination of your disability to the Group within 60 days of receipt. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least

until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Group of that fact within 30 days after SSA's determination.

- **Second Qualifying Event**

An 18-month extension of coverage will be available to spouses and Dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered Subscriber, divorce or separation from the covered Subscriber, the covered Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Group's health plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Group within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

### **Trade Act of 1974**

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

## Premiums and the End of COBRA Coverage

Premium will be no more than 102% of the Group rate (unless your coverage continues beyond 18 months because of a disability. In that case, premium in the 19th through 29th months may be 150% of the Group rate).

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the Group ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Group would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

## Other coverage options besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

## If You Have Questions

Questions concerning your Group's health plan and your COBRA continuation coverage rights

should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of 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](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

## Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under this Certificate in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Certificate by notifying your employer in advance and payment of any required contribution for health coverage. This may include the amount the Employer normally pays on your behalf. If Your military service is for a period of time less than 31 days, You may not be required to pay more than the active Member contribution, if any, for continuation of health coverage.

If continuation is elected under this provision, the maximum period of health coverage under this Certificate shall be the lesser of:

1. The 24-month period beginning on the first date of your absence from work; or
2. The day after the date on which You fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under this Certificate. No exclusions or waiting period may be imposed on you or your eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

### Family and Medical Leave Act of 1993

A Subscriber who is taking a period of leave under the Family and Medical Leave Act of 1993 (the

Act) will retain eligibility for coverage during this period. The Subscriber and his or her Dependents shall not be considered ineligible due to the Subscriber not being Actively At Work.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without underwriting and without imposition of an additional waiting period. To obtain coverage for a Subscriber upon return from leave under the Act, the Group must provide the Plan with evidence satisfactory to Us of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

## 5 HOW TO OBTAIN COVERED SERVICES

### Network Services and Benefits

If a Network Provider renders your care, benefits will be provided at the Network level. Refer to the Schedule of Benefits. No benefits will be provided for care that is not a Covered Service even if performed by a Network Provider.

We may inform you that a service you received is not a Covered Service under the Certificate. You may appeal this decision. See the Complaint and Appeals Procedures section of this Certificate.

**Network Providers** are professional Providers and other facility Providers who contract with Us to perform services for you. You will not be required to file any claims for services you obtain directly from Network Providers.

### Non-Network Services and Benefits

Services that are not obtained from a Network Provider will be considered a Non-Network Service. In addition, certain services may not be covered unless obtained from a Network Provider, and/or may result in higher cost-share amounts. See your Schedule of Benefits. You will be required to file claims for services that you obtain directly

from a Non-Network Provider.

### Relationship of Parties (Plan - 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, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Provider or in any Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network and Non-Network Providers. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or Us.

## Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Certificate does not

give anyone any claim, right, or cause of action against the Plan based on what a Provider of vision care, services or supplies, does or does not do.

## 6 COVERED SERVICES

This section describes the Covered Services available under your vision care benefits when provided and billed by eligible Providers. 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 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.

The following are Covered Services:

- Routine Vision examinations
- Standard Eyeglass Lenses
- Frames
- Contact Lenses in lieu of Eyeglass Lenses

Services and materials obtained through a Non-Network Provider are subject to the same Exclusions and limitations as services through a Network Provider.

If you choose a set of frames that are valued at more than the Maximum Allowable Amount, you are responsible for the difference in cost.

If a Member elects either covered Non-Elective or Elective Contact Lenses within one 12-month period, no benefits will be paid for covered Lenses and frames until the next 12-month period.

### Vision Eye Examination

The Plan covers up to a comprehensive eye examination including dilation as needed minus

any applicable Copayment. The eye examination may include the following:

- Case history
- Recording corrected and uncorrected visual acuity
- Internal exam
- External exam
- Pupillary reflexes
- Binocular vision
- Objective refraction
- Subjective refraction
- Glaucoma test
- Slit lamp exam (Biomicroscopy)
- Dilation
- Color vision
- Depth perception
- Diagnosis and treatment plan.

### Eyeglass Lenses

Eyeglass Lenses are available in standard or basic plastic (CR39) Lenses including single vision, bifocal, and trifocal with factory coating with polycarbonate lenses for children under 19 and photochromic lenses for children under 19. If you choose progressive Lenses that are no line bifocals, there will be an additional cost. All eyeglass Lenses are subject to the applicable

Copayment listed in the Schedule of Benefits. There may also be an additional cost for any add-ons to the Lenses such as anti-reflective coating or ultra-violet coating. These and any other lens add-ons may be discounted according to Our Additional Savings Program.

## Frames

The frame allowance is based upon the retail cost. The Member may apply the plan allowance toward the Network Provider's selection of frames. The Schedule of Benefits lists the frames allowance available under your plan. If you choose a set of frames that are valued at more than the Maximum Allowable Amount, you are responsible for the balance based upon the Additional Savings Program.

## Elective Contact Lenses

The contact lens allowance must be completely used at the time of initial service. No amount of the allowance may be carried forward to use during another service date. The Schedule of Benefits lists the contact lens allowance available under this Certificate.

## Non-Elective Contact Lenses

This benefit is available for a limited number of diagnoses and is in lieu of the standard contact lens or Lenses and frames benefit.

### Eligibility

Conditions that provide eligibility for consideration of this Non-Elective Contact Lens benefit include:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle Lenses.
- High Ametropia exceeding -12 D or +9 D in spherical equivalent.

- Anisometropia of 3 D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle Lenses.

## Fitting Fees

The Member is responsible for 100% of the fitting fee at the time of service. However, Our Maximum Allowable Amount reimbursement paid to the prescribing Provider for Non-Elective Contact Lenses may include a portion, or all, of the fitting fee. Any remaining amount will be applied to the Provider's fitting fee.

**SPECIAL NOTE:** We will not reimburse for Non-Elective Contact Lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

## Cosmetic Options

Benefits are available for the services below in accordance with the Additional Savings Program. The Member will be responsible for the following items at a discounted rate when provided by a Network Provider.

- Blended Lenses
- Contact Lenses (except as noted herein)
- Oversize Lenses
- Progressive multifocal Lenses
- Photochromatic Lenses, or tinted Lenses
- Coated Lenses
- Frames that exceed the Maximum Allowable Amount
- Cosmetic Spectacle Lenses
- Ultra-violet coating
- Scratch resistant coating
- Polycarbonate Lenses



- Anti-reflective coating

- Optional cosmetic items

## 7 EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items that may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or supplies are Covered Services.

We do not provide vision benefits for services, supplies or charges:

1. Received from an individual or entity that is not a Provider, as defined in this Certificate.
2. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
3. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
4. For illness or injury that occurs as a result of any act of war, declared or undeclared.
5. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
6. For which you have no legal obligation to pay in the absence of this or like coverage.
7. Received from an optical or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
8. Prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
9. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
10. For missed or canceled appointments.
11. In excess of Maximum Allowable Amount.
12. Incurred prior to your Effective Date.
13. Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.
14. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
15. For sunglasses and accompanying frames.
16. For safety glasses and accompanying frames.
17. For inpatient or outpatient hospital vision care.
18. For Orthoptics or vision training and any associated supplemental testing.
19. For non-prescription lenses.
20. For two pairs of glasses in lieu of bifocals.
21. For Plano lenses (lenses that have no refractive power).
22. For medical or surgical treatment of the eyes.
23. For lost or broken Lenses or frames, unless the Member has reached his or her normal interval for service when seeking replacements.
24. For services or supplies not specifically listed in the Certificate.

25. Certain brands on which the manufacturer imposes a no discount policy.

26. For services or supplies combined with any other offer, coupon or in-store advertisement.

## 8 CLAIMS PAYMENT

### Obtaining Services/Claim Payment

For services received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. If you elect to obtain services from a Non-Network Provider, you must pay the entire bill at the time the services are rendered. To request reimbursement for Covered Services We will need the following information:

- The name, address and phone number of the Non-Network Provider along with an itemized statement of charges
- The covered Member's name and address, group number, Social Security number or Member identification number
- The patient's name, birthdate and relationship to the Member

The Member should keep a copy of the information and send the originals to the following address:

BlueView Vision Claims Administration  
PO Box 8504  
Mason, OH 45040-7111

### Assignment

This Certificate is not assignable by the Group without the written consent of the Plan. The coverage and any benefits under this Certificate are not assignable by any Member without the written consent of the Plan, except as described in this Certificate.

### Notice of Claim

We are not liable under the Certificate, unless We receive written notice that Covered Services have been given to you. An expense is considered incurred on the date the service or supply was given.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice can be submitted later than one year after the usual 90 day filing period ends. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

### Claim Forms

Many Providers will file for you. If the forms are not available, either send a written request for claim forms to Us or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician's signature

## Proof of Claim

Written proof of claim satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of claim is not sent within the time required, the claim will not be reduced or denied if it was not possible to do send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

## Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Certificate, We may reimburse those

other parties and be fully discharged from that portion of its liability.

## Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate will be responsible for any charge for services.

## Explanation of Benefits

After you receive vision care, you will often receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you received. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by your coverage;
- the amount for which you are responsible (if any);
- general information about your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.

# 9 GENERAL PROVISIONS

## Entire Contract

Note: The laws of the state in which the Group Contract was issued will apply unless otherwise stated herein.

This Certificate, the Group Contract, the Group application, any Riders, Endorsements or

Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire Contract between the Plan and the Group and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Group and any and all statements made to the Group by the Plan are representations and not warranties, and

no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

### **Form or Content of Certificate**

No agent or employee of the Plan is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by an officer of the Plan.

### **Circumstances Beyond the Control of the Plan**

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Plan, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of vision care services provided under this Certificate is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render services provided under this Certificate insofar as practical, and according to their best judgment; but the Plan and Network Providers shall 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**

We consider this Plan primary in all circumstances.

### **Other Government Programs**

Except insofar as applicable law would require the Plan to be the primary payer, the benefits under this Certificate shall not duplicate any benefits to

which Members are entitled or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

### **Right of Recovery**

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 12 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, or Vendor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

### **Relationship of Parties (Group-Member-Plan)**

Neither the Group nor any Member is the agent or representative of the Plan.

The Group is fiduciary agent of the Member. The Plan's notice to the Group will constitute effective notice to the Member. It is the Group's duty to notify the Plan of eligibility data in a timely manner. The Plan is not responsible for

payment of Covered Services of Members if the Group fails to provide the Plan with timely notification of Member enrollments or termination's.

## Conformity with Law

Any provision of this Plan that 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

This Certificate allows the Group to make the Plan coverage available to eligible Members. However, this Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Group Contract, or by mutual agreement between the Plan and the Group without the permission or involvement of any Member. Changes will not be effective until 30 days after We provide written notice to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting the 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 in this Certificate.

## Physical Examination and Autopsy

We shall have the right to: (1) examine any Member for whom a claim is made when and as often as may be reasonably required during the pendency of a claim; and (2) perform an autopsy on any Member where it is not otherwise prohibited by law.

## Clerical Error

Clerical error, whether of the Group or the Plan, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in

force or continue coverage otherwise validly terminated.

## Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Complaint and Appeals Procedures before filing a lawsuit or other legal action of any kind against Us.

## Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which a Member shall comply.

## Waiver

No agent or other person, except an authorized officer of the Plan, is able to disregard any conditions or restrictions contained in this Certificate, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

## Plan's Sole Discretion

The Plan may, in its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of a Member.

## 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.

## Anthem Blue Cross and Blue Shield Note

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Certificate constitutes a contract solely between the Group and Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

## 10 COMPLAINT AND APPEALS PROCEDURES

Our customer service representatives are specially trained to answer your questions about Our vision benefit plans. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Copayment amounts;
- Specific claims or services you have received;
- Providers in the Network; and/or
- Provider directories.

You will be notified, in writing, if a claim or other request for benefits is denied in whole or in part. If such a request is denied, the notice of denial will explain why benefits were denied and describe your rights under the Appeals Procedure. A Complaint Procedure also exists to help you understand the Plan's determinations.

### The Complaint Procedure

A Complaint Procedure is available to provide reasonable, informative responses to complaints

that you may have concerning the Plan. A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Plan of its procedures and contracts. The Plan invites you to share any concerns that you may have over benefit determinations, coverage cancellations, or the quality of care rendered by Vision Providers in the Plan's Networks.

If you have a complaint or problem concerning benefits or services, please contact Us. Please refer to your Identification Card for Our address and telephone number. You may submit your complaint by letter or by telephone call. Or, if you wish, you may meet with your local service representative to discuss your complaint.

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.

## The Appeals Procedure

An appeal is a formal request from you for the Plan to change a previous determination. If you are notified in writing of a Coverage Denial or any other adverse decision by Us, you will be advised of your right to an internal appeal.

A Coverage Denial means Our determination that a service, treatment, drug or device is specifically limited or excluded under this Certificate.

The internal appeals process may be initiated by the Member, the Member's authorized representative, or a Provider acting on behalf of the Member within 60 days of receipt of Our written notice of a Coverage Denial, or any other adverse decision made by Us, but must be filed within six months of your receipt of the initial decision. The request should include any medical information pertinent to the appeal. All portions of the medical records that are relevant to the appeal and any other comments, documents, records or other information submitted by the Member relating to the issue being appealed, regardless of whether such information was considered in making the initial decision, will be

considered in the review of the appeal. Any new medical information pertinent to the appeal will also be considered. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal.

If a representative is seeking an appeal on behalf of a Member, We must obtain a signed Designation of Representation (DOR) form from the Member. The appeal process will not begin until Anthem has received the properly completed DOR. We will forward a Designation of Representation form to the Member for completion.

The individuals responsible for reviewing your request for an internal appeal will not be the same individuals who made the initial denial or determination. They will not be the subordinates of the initial decision-maker either and no deference will be given to the initial decision.

Within a reasonable period of time but no later than 30 days after receiving a written or an oral request for an appeal, We will send a written decision to the Member or their authorized representative.

## Contact Person For Appeals

The request for an internal appeal must be submitted to the following address or telephone number or to the appeal address or telephone number provided on your written notice of an adverse decision:

Blue View Vision  
ATTN: Appeals  
555 Middle Creek Parkway  
Colorado Springs, CO 80921

Telephone Number: 866-723-0515

The person holding the position named above will be responsible for processing your request.

The Plan encourages its Members to submit requests for appeal in writing. The request for appeal should describe the problem in detail.

Attach copies of bills, medical records, or other appropriate documentation to support the appeal that may be in your possession.

You must file appeals on a timely basis. As state above, you are encouraged to file internal appeals within 60 days of your receipt of the Plan's initial decision. Internal appeals must be filed, however, within six months of your receipt of the initial decision.

### **Vision Services**

We are not liable for the furnishing of Covered Services, but merely for the payment of them. You shall have no claim against Us for acts or omissions of any Provider from whom you receive Covered Services. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

### **Limitation of Actions**

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure before filing a lawsuit or other legal action of any kind against the Plan. If your vision benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.





**AIC-VIS01(ASO)**

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Indiana  
Life and Health  
Insurance  
Guaranty  
Association  
Disclaimer

# Notice Of Protection Provided By The Indiana Life And Health Insurance Guaranty Association

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

## **Basic Protections Currently Provided by ILHIGA**

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

### **Life Insurance**

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

### **Health Insurance**

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

### **Annuities**

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

**Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.**

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at [www.inlifega.org](http://www.inlifega.org) or contact:

Indiana Life & Health Insurance  
Guaranty Association  
3502 Woodview Trace Suite 100  
Indianapolis, IN 46268  
317-636-8204

Indiana Department of Insurance  
311 West Washington Street, Suite 103  
Indianapolis, IN 46204  
317-232-2385

**The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.**

**Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.**

**Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.**

**Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.**

**Notice:****The accompanying contract does not provide prepaid services or merchandise under Indiana Code 30-2-13.**

This life insurance policy and certificate does not entitle the policyholder, certificateholder or any other person to:

- prepaid services or merchandise in conjunction with the death, funeral, burial, or final disposition of the insured under IC 30-2-13; or
- the right to file a complaint with the Indiana State Board of Funeral and Cemetery Service established by IC 25-15-9-1 for restitution from the preneed consumer protection fund under IC 30-2-13-29;

unless ownership of the certificate is irrevocably assigned to a trustee to fund a contract entered into with a seller (as defined under IC 30-2-13-10) under IC 30-2-13.

This life insurance policy and certificate:

- is not guaranteed to be exempt as a resource in determining eligibility for Medicaid under IC 12-15-2-17; and
- does not guarantee Medicaid eligibility.

Medicaid eligibility determinations are made in accordance with applicable Medicaid laws and policies.



*Underwritten by Anthem Insurance Companies, Inc.*

# Notice of Privacy Practices



## Information That's Important to You

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits

Want to save more trees? Go to [anthem.com](http://anthem.com) and sign up to receive these types of notices by e-mail.

## State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

## Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company - without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity. You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

## HIPAA notice of privacy practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.



## Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

**For payment:** We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.

**For health care operations:** We use and share PHI for health care operations.

**For treatment activities:** We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital.

### **Examples of ways we use your information for payment, treatment and health care operations:**

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit <https://www.anthem.com/health-insurance/about-us/privacy> for more information.

**To you:** We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

**To others:** In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice may also require your written OK. You always have the right to revoke any written OK you provide.

You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI for other types of activities including:

- Health oversight activities;
- Judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents);

- Organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety;
- Special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes; and
- As required by law.

If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI - unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

**Authorization:** We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

**Genetic information:** We cannot use or disclose PHI that is an individual's genetic information for underwriting.

## Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.
- Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to Anthem, Anthem does not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, Anthem does not have to agree to your restriction.

## **How we protect information**

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We have to keep your PHI private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law and outlined in this notice.

## **Potential Impact of Other Applicable Laws**

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

## **Contacting you**

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment, or billing.

## **Complaints**

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

## **Contact Information**

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

## **Copies and Changes**

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

**Effective Date of this notice**

The original effective date of this Notice was April 14, 2003. The most recent revision date is indicated in the footer of this Notice.

**Breast reconstruction surgery benefits**

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance. Contact your Plan administrator for more information.

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In most of Missouri: RightCHOICE<sup>®</sup> Managed Care, Inc. (RIT), Healthy Alliance<sup>®</sup> Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross and Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWi collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. <sup>®</sup> ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.





Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Group Name: NAMIC Group Insurance Trust

Group Identification Number: 00248425

Subgroup Identification Number:

