

Vision Certificate of Coverage

(herein called the "Certificate")

EFFECTIVE JANUARY 1, 2023

Blue View Vision

STATE OF GEORGIA

SELECT PLAN

**Anthem Blue Cross and Blue Shield
Corporate Headquarters
740 W Peachtree Street NW
Atlanta, GA 30308**

Introduction

Welcome!

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

- this booklet (your Certificate)
- your application
- any endorsements, amendments or riders

Your Group (also referred to as your employer) also has the following documents which are part of the terms and conditions of this Plan:

- the Group Contract (you may request a copy of this from your Group's human resources or benefits department)
- the Group's master application

This Certificate contains important information about your *plan*, such as what vision care services are covered and how they will be covered. It replaces any older version of the Certificate you may have for this vision plan.

Within the Certificate, Members may be referred to as "you" or "your". Anthem is referred to as "we", "us" or "our". All capitalized words have special meanings that are defined where they are used or in the Definitions section of this Certificate.

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



President

Contact Us

If you have questions about your coverage or need help finding a Blue View Vision Network Provider, please contact us.

Member Services

Please send your general inquiries, suggestion or comments to:

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

Please send claims to:

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

Please send appeals to:

Anthem Blue View Vision
Attention: Appeals
P.O. Box 9304
Minneapolis, MN 55440-9304
Phone: (866) 723-0515

Hours of operation

Monday – Saturday: 8:30 a.m. to 11:00 p.m. Eastern Time
Sunday: 11 a.m. to 8:00 p.m. Eastern Time

Visit Us Online

Learn more about Blue View Vision, our Network Providers, and more by visiting us at: www.anthem.com.

How to Get Language Assistance

Anthem is committed to communicating with our members about their health plan, no matter what their language is. We employ a language line interpretation service for use by all of our customer service call centers. Simply call the member services phone number above and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting member services. TTY/TDD services are also available by dialing 711. A special operator will get in touch with us to help with your needs.

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

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number on the back of your ID Card or in your Certificate of Coverage.

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Schedule of Benefits

This Schedule of Benefits is just a summary of your benefits. Please refer to the Covered Services section of this *certificate* 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 Plan.

CHOICE OF VISION CARE PROVIDER: Nothing contained in this Certificate restricts or interferes with your right to select the vision care Provider of your choice, but your benefits may be reduced when you use a Non-Network Provider.

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network Providers	Non-Network Providers
Exam Limited to one exam per Calendar Year	\$10 Copay	Reimbursed Up To \$40
Prescription Lenses (including factory scratch coating, polycarbonate lenses for children under 19 years old and Photochromic lenses for children under 19 years old when received from network providers). Limited to one set of lenses per member once every calendar year.		
Basic Lenses (Pair)		
• Single Vision lenses	\$20 Copay	Reimbursed Up To \$40
• Bifocal lenses	\$20 Copay	Reimbursed Up To \$60
• Trifocal lenses	\$20 Copay	Reimbursed Up To \$80
• Lenticular lenses	\$20 Copay	Reimbursed Up To \$80
Frame Limited to one set of frames per member once every other calendar year	\$130 Allowance	Reimbursed Up To \$45
Prescription Contact Lenses (traditional or disposable)		
Note: Contact lenses are in lieu of your eyeglasses benefit. If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in this Schedule of Benefits.		
• Elective Contact Lenses Availability once every Calendar Year	No copayment, \$105 allowance	Reimbursed Up To \$105
• Non-Elective Contact Lenses Availability once every Calendar Year	Covered in Full	Reimbursed Up To \$210

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.

Additional Savings In-Network Providers Only	In-Network Cost (after any applicable Copayment)
Retinal Imaging (Can be performed at time of eye exam.)	Not more than \$39
Eyeglass Lens Upgrades	
• Transitions Lenses (Adults)	\$75
• Standard Polycarbonate (Adults)	\$40
• UV Coating	\$15
• Progressive Lenses	
○ Standard	\$65
○ Premium Tier 1	\$85
○ Premium Tier 2	\$95
○ Premium Tier 3	\$110
• Anti-Reflective Coating	
○ Standard	\$45
○ Premium Tier 1	\$57
○ Premium Tier 2	\$68
• Tints	\$0
• Other Add-ons and Services	20% off retail price
Frames	20% off remaining balance after allowance applied
Additional Pairs of Eyeglasses	
• Complete Pair	40% off retail price
• Eyeglass materials purchased separately	20% off retail price
• Other items: non-prescription sunglasses, lens cleaning, supplies, contact lens solutions, etc.	20% off retail price
Contact Lenses Fit and Follow-up (Available following a comprehensive eye exam)	
• Standard lens fitting	Up to \$55
• Premium lens fitting	10% off retail price
Conventional Contact Lenses (Available after covered benefits have been used. Discount applies to materials only.)	
	15% off retail price

Definitions

This section defines terms that have special meanings. If a word or phrase has a special meaning 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 or Active Work means that the Subscriber is present and capable of carrying out the normal assigned duties of his or her job. This must be done at:

- The Policyholders' place of business;
- An alternate place approved by the Policyholder; or
- A place to which the Policyholder's business requires Subscriber to travel

Subscriber will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays or business closures if Subscriber is Actively at Work on the last scheduled work day preceding such time off.

Basic Lenses. Standard plastic (CR-39) Lenses in Single, Bifocal, Trifocal, Lenticular or Progressive.

Calendar Year. The period of time that benefits are tracked from January 1st to December 31st. The Member must wait until the calendar year interval of which they can receive Covered Services as listed in the Schedule of Benefits.

Certificate. This booklet, which is a summary of the terms and conditions of your benefits. It is attached to and is a part of the Group Contract and is subject to the terms of the Group Contract.

Copayment (or Copay). A specific dollar amount that you are responsible to pay for Covered Services. See the Schedule of Benefits for your copayment amounts.

Covered Services. Services, supplies or treatment that are listed as covered in this Certificate. A covered service is incurred on the date the service, supply or treatment was provided to you. In order to be a covered service the services, supply or treatment must be:

- within the scope of the license of the Provider performing the service;
- given while coverage under this Certificate is in force;
- Within the Maximum Allowable Amount;
- Not specifically excluded or limited by the Certificate;
- Specifically included as a benefit within the Certificate.

Dependent. A member of the Subscriber's family that may be covered under this Plan. See the Eligibility and Enrollment Section of this Certificate for more information on which family members are considered dependents.

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 are not 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 Anthem and the Group. It includes this Certificate, your and your Group's applications, any supplemental application or change form, your ID card, and any amendments, 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 that benefits and frequencies are tracked. When you get a Covered Service, you must wait a period of time from the last date of service before you we will pay for the Covered Service again. See the Schedule of Benefits for the benefit frequencies.

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

Maximum Allowable Amount. The maximum amount we will pay for *covered services*. See the section How Your Plan Works for more information on how we determine the maximum allowable amount.

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 with 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:

- Keratoconus: a condition where the patient is not correctable to 20/30 in either or both eyes using standard spectacle Lenses and the Vision Care Provider attests to visual improvement.
- High Ametropia exceeding -10 D or +10 D in spherical equivalent in either eye.
- Anisometropia of 3 D or more in spherical equivalent.
- Patients whose vision can be corrected two (2) lines of improvement on the visual acuity chart with Contact Lenses as compared to best corrected visual acuity with standard spectacle Lenses.
- Cataract surgery without intraocular lens implant.

Non-Network Provider. A Provider who has not agreed to service the network associated with this Plan. See the section How Your Plan Works for more information on non-network providers.

Open Enrollment. A period of time in which employees are eligible to make benefit selections for the next benefit plan year.

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

Premium. The periodic charges that the Group must pay us to maintain coverage. You may be responsible to pay a portion of the premium. See your Group’s human resources or benefits department for more information.

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

Qualifying Event. An event defined by the IRS in Section 125 that allows changes outside the initial enrollment period after a qualifying event and/or Open Enrollment due to the gain or loss of Dependent due to marriage, divorce death, birth.

Qualified Beneficiary. The individual who was covered as an active employee or employee on an approved leave of absence without pay; or a person who was covered as a spouse or eligible Dependent of an active employee, or employee on approved leave of absence without pay on the day the insurance option was lost as a result of a qualifying event is now eligible to continue under the requirements of federal law and regulation known as the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Subscriber. An employee, retiree, or other member of the Group that is eligible to enroll in this Plan. Subscriber eligibility requirements are determined by the Group. See the section Eligibility and Enrollment for more information.

Eligibility and Enrollment

Eligible Employee means an employee of an Employer who is Actively At Work for the required minimum number of hours to participate in the Policyholder's Flexible Benefits Program and who meets all other requirements to participate in the State of Georgia's Flexible Benefits Program.

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. You will become eligible for insurance on the day you complete the waiting period if:

- You are in a Class of Eligible Employees;
- You are a full-time Employee of a State of Georgia participating agency, working at least 30 hours per week, on a continuous basis, and whose employment is expected to last at least nine (9) months, or
- You are a public school teacher who is employed in a professionally certificated capacity, working 17.5 hours or more per week, or
- You are the Employee of a local school system who holds a non-certificated position and is eligible to participate in the Teachers Retirement System and working at least 20 hours per week or 60% of the time necessary to carry out the duties of the position, if that is more than 20 hours per week, or
- You are an Employee who is eligible to participate in the Public School Employee retiree System and who works at least 15 hours per week or 60% of the time necessary to carry out the duties of the position, if that is more than 15 hours per week, or
- You are an Employee of a county or regional library and working 17.5 hours or more, and
- Others deemed eligible by Federal or Georgia Law.

Dependents

If you are covered by this program, you may enroll eligible Dependents. Your covered Dependents are also called Members.

If the wrong birthdate of a child is entered, the child has no coverage for the period for which he or she is not legally eligible. Any overpayments made for coverage for any child under these conditions will be refunded by either you or Anthem.

Your Eligible Dependents Include:

- Your legal wife or husband (spouse).
- Your Dependent children through the end of the month in which they attain age 26, legally adopted children from the date you assume legal responsibility, children for whom you assume legal guardianship and stepchildren. Also included are your children (or children of your spouse) for whom you have legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on you for support, regardless of age with the exception of incapacitated children age 26 or older. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Certificate or prior Creditable Coverage prior to reaching age 26. Certification of the disability is required within 31 days of attainment of age 26. A certification form is available from your employer or from Anthem and may be required periodically but not more frequently than annually after the two year period following the child's attainment of the limiting age.
- The Subscriber or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a "Qualified Medical Child Support Order" as defined by any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

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.

Continued on next page

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.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under the Plan unless required by the laws of this state.

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

Enrollment

Initial Enrollment

An Eligible Person can only enroll for coverage during the Open Enrollment period, if they have a Qualifying Event, or as a newly hired eligible employee, or during a Special Enrollment period, which-ever is applicable.

Newly hired eligible employees have 31 days from the date of hire to enroll in this plan. If they do not apply within the initial 31 days, they will not be able to enroll until they have a Qualifying Event, during a Special Enrollment period, or the next Open Enrollment period.

If a person qualifies as a Dependent but is not enrolled when the Eligible Person first applies for enrollment, the Dependent can only be enrolled for coverage during the Open Enrollment period or during a Special Enrollment period, whichever 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.

Special Enrollment Periods (for Qualifying Events)

If a Subscriber or Dependent does not apply for coverage when they were first eligible, then they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a Qualifying Event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of Premium or due to fraud or intentional misrepresentation of material fact.
- Exhausted COBRA benefits or employer contributions toward coverage were terminated.
- Lost employer contributions towards the cost of the other coverage.
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a Qualifying Event (i.e. marriage, exhaustion of COBRA, etc.).
- When you enroll during Special Enrollment, coverage under the Plan is effective the 1st of the month following the Qualifying Event.

Foster Children

Foster children are children of those whose parental rights have been terminated by the state and who have been placed in an alternative living situation by the state. A child does not become a foster child when the parents voluntarily relinquish parental power to a third party.

Foster children for whom a Member assumes legal responsibility are not covered automatically. In order for a foster child to have coverage, a Member must provide confirmation of a valid foster parent relationship. The Effective Date will be the first of the month following your Group's employee waiting period.

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, enrollment must be completed within 31 days of the date legal custody or guardianship is awarded by the court. If not enrolled within the 31 day eligibility period, the child will not be eligible for coverage until the next Open Enrollment.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by applicable state or federal law, to enroll your child under this 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.

Open Enrollment Period

An Eligible Person or Dependent not enrolled for coverage during the initial enrollment period, or during a Special Enrollment period, will not be eligible to enroll until the Group's next Open Enrollment.

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.

Notice of Changes

You are responsible to notify your Group of any changes which will affect your or your Dependent's eligibility under this Plan. This includes a change in address or a change in the number of your Dependents. The Group is then responsible to notify us of any changes according to the terms of the Group Contract. Changes to your or your Dependent's eligibility may result in a change in the Premium. If your Group fails to notify us of your changes in eligibility or to pay the required Premium, it does not obligate us to pay for your vision care.

Statements and Forms

You must complete and submit any necessary applications, or other forms or statements, we may reasonably request. Any rights to benefits under this plan are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by you may result in termination of coverage as provided in the section Termination and Continuation of this Certificate. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply to fraudulent misstatements.

Effective Date of Coverage

Your Effective Date is the date coverage begins under this Plan. Your Effective Date is listed on your ID card for this Plan. See your Group's human resources or benefits department for more information on your Effective Date.

Statement

Members should understand that all rights to benefits under this Certificate are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a Member may result in termination of coverage as provided in the " Termination and Continuation" section.

Delivery of Documents

An Identification Card will be provided for each Subscriber. Access to the Certificate will be made available electronically.

Termination and Continuation

Termination of Coverage (Group)

Anthem may cancel this Certificate in the event of any of the following:

- The Group fails to pay premiums in accordance with the terms of the group contract.
- The Group performs an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage.
- We terminate cancel or non-renew all coverage under a particular policy form, provided that:
 - We provide at least 270-day notice of the termination of the policy form to all Members and the Group during the calendar year of the Effective Date.
 - We offer the Group all other small (employer) or large group (employer) policies, depending on the size of the Group, currently being offered or renewed by Us for which you are otherwise eligible; and
 - We act uniformly without regard to the claims experience or any health status related factor of the individuals insured or eligible to be insured.

Termination of Coverage (Individual)

Group program membership for you and your enrolled family members may be continued as long as you are employed by the Group and meet eligibility requirements. It ceases if your employment ends, if you no longer meet eligibility requirements, if the Group Contract ceases, or if you fail to make any required contribution toward the cost of your coverage. In any case, your coverage would end at the expiration of the period covered by your last contribution.

Coverage of an enrolled child ceases automatically at the end of the month in which the child attains age 26. Coverage of a disabled child over age 26 ceases at the end of the month if the child is found to be no longer totally or permanently disabled. Coverage of the spouse of a Member terminates automatically as of the date of divorce or death.

If you engage in fraudulent conduct or furnish Us fraudulent or misleading material information relating to claims or enrollment for coverage, then We may terminate your coverage. Termination is generally effective 30 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.

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

A Subscriber may cancel the enrollment of any of their Dependents from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Reinstatement

If coverage lapses because the Premium has not been paid within the time allowed, you will not be reinstated automatically. You may have to reapply for your coverage. If this coverage ends because of an inadvertent clerical error, reapplication is not necessary. Your coverage will not be negatively affected as a result of the Group's clerical error. However, the Group is liable to us if we incur financial loss as a result of their clerical error.

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

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of vision coverage under the Group's vision 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 vision Plan is lost because of the qualifying event. Under the Group's vision 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 vision 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 vision 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; or You become divorced or legally separated from your spouse.
- Your spouse becomes enrolled in Medicare (Part A, Part B, or both)

Your Dependent children will become qualified beneficiaries if they lose coverage under the Group's vision 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 parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Group's vision Plan as a "Dependent child."
- The parent Subscriber becomes enrolled in Medicare (Part A, Part B, or both)

When is COBRA Coverage Available

COBRA continuation coverage will be offered 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 you must notify the Group 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.

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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.

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the Subscriber, the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts 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. For example, if a covered Subscriber becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Group's vision Plan is determined by the Social Security Administration to be disabled and you notify the Group in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have 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.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Group. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Subscriber or former Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Group's vision Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Group's vision Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health Plans, contact the 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. (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 vision 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 the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty, and a period for which a person is absent from employment for the purpose of performing funeral honors duty as authorized by section 12503 of title 10 ([10 USCS § 12503](#)) or [section 115](#) of title 32 ([32 USCS § 115](#)).

Continued on next page

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 vision coverage. 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 vision coverage.

If continuation is elected under this provision, the maximum period of vision 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 vision coverage, if you return to your position of employment your vision 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 medical underwriting and without imposition of an additional waiting period for Pre-Existing Conditions. To obtain coverage for a Subscriber upon return from leave under the Act, the Group must provide the Plan with evidence satisfactory to Anthem, including a copy of the health care provider statement allowed by the Act.

How to Obtain Covered Services

Services and Benefits

Services obtained from any licensed out-of-network Provider will be considered reimbursed directly to the Member according to the Member Reimbursement Amount listed in the Schedule of Benefits. Certain services may have additional out-of-pocket costs. You will be required to file claims for all out-of-network services.

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.

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.

Covered Services

This section describes the Covered Services available under your vision care benefits. 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 the type of services and whether or not you choose optional services and/or custom materials rather than standard services and supplies. Payment amounts are specified in the Schedule of Benefits.

PAYMENT AMOUNTS AND BENEFIT FREQUENCIES ARE SPECIFIED IN THE SCHEDULE OF BENEFITS

Comprehensive Vision Examination. A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of correction eyewear where indicated. This does not include Contact Lens fitting fee.

Frames. The Provider will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency. If you go to a Network Provider and you choose frames that cost more than the benefit maximum shown under the Schedule of Benefits, your cost will be based on a discounted arrangement.

Eyeglass Lenses. The Provider will order the proper Lenses necessary for your visual welfare. The Provider will verify the accuracy of the finished Lenses. Covered Lenses include plastic (CR39):

1. Single vision;
2. Bifocal;
3. Trifocal (FT25-28);
4. Lenticular

Benefits include factory scratch coating and tint (solid & gradient). Please refer to the benefits chart on page 2. You will be responsible for amounts in excess of the benefit maximum. Transitions Photochromic and polycarbonate Lenses prescribed for a child under age 19 are covered in full.

Elective Contact Lenses. You have an allowance once every 12 months toward elective cosmetic prescription contact lenses selected in lieu of the eyeglass lens benefit. Non-prescription contacts are not included. If you choose contact lenses greater than the allowance, you are responsible for the difference. If you choose to receive contact lenses, no benefits will be paid for Lenses during that same Benefit Period.

Non-Elective Contact Lenses*. Non-elective Lenses are provided for reasons that are not cosmetic in nature and have a maximum benefit as indicated in the Schedule of Benefits. Non-Elective Contact Lenses are covered when the following conditions have been identified or diagnosed:

1. Extreme visual acuity or other functional problems that cannot be corrected by spectacle Lenses; or
2. Keratoconus - unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; or
3. High Ametropia - unusually high levels of near sightedness, far sightedness, or
4. Anisometropia - when one eye requires a much different prescription than the other eye.
5. Cataract surgery without intraocular lens implant

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

Fitting Fees. A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Cosmetic Options. Benefits are available for the services listed in the lens option chart on page 2 in accordance with the Additional Savings Program. The Member will be responsible for those items at a discounted rate when provided by a Network Provider.

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 Workers' 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 nonprescription 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 prescription glasses in lieu of bifocals as outlined in the certificate of coverage
21. For Plano Lenses (Lenses that have no refractive power).
22. For medical or surgical treatment of the eyes that requires the service of a physician.
23. 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. For certain Frame brands in which the manufacturer imposes a no discount policy (ask Provider for details). For services or supplies combined with any other offer, coupon or in- store advertisement.
26. For the following:
 - Cosmetic Spectacle Lenses
 - Optional cosmetic items

How to File a Claim

How to File a Claim

You are responsible for getting claims filed after you receive vision care. However, if you receive vision care from a Network Provider they will typically file claims on your behalf.

If you receive care from a Non-Network Provider you must submit the claim.

For Corporate owned Walmart locations and Sam's Club locations please use the custom Walmart/Sam's Club out-of-network claim form for submission. Services received at a Corporate-owned Walmart/Sam's Club will be reimbursed as an in-network benefit in accordance with the benefit schedule listed on pages 1 & 2 in this certificate.

After you receive vision care you will need to contact Us, either by phone or mail, within 20 days of your vision care so We can provide you claim forms for filing. If you are unable to contact Us within 20 days, you should contact Us as soon as possible. We will provide claim forms within 15 days for you to file. The claim form will have instructions on how to fill it out and where to mail it.

We must receive the claim form within 90 days from the date you had your vision care. If you are not able to send the claim within 90 days We will not void or reduce your claim. However, you must send it as soon as possible, and in no event no later than a year from when it was due unless you are legally incapacitated.

If you do not receive a claim form within 15 days after you request one, you may send Us an itemized bill instead. The itemized bill must include all of the following:

- the date of service;
- the patient's name, date of birth, and identification number; the type and place of service;
- your signature and the Provider's signature or authorized signature stamp.

Please send claims and itemized bills to one of the following:

Anthem Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111
855-556-4844

Email: OONclaims@eyewearspecialoffers.com

Fax: 1-866-293-7373

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.

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, Workers' 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 receive. 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.

General Provisions

Entire Contract

Note: The law 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 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 Providers shall render services provided under this Certificate insofar as practical, and according to their best judgment; but the Plan and 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.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, 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 24 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 terminations.

Conformity with Law

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

Modifications

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.

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.

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 Reimbursement amounts or specific claims or services you have received.

You will be notified, in writing, if a claim or other request for benefits is denied in whole or in part. If 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 or coverage cancellations

If you have a complaint or problem concerning benefits or services, please contact Us. 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.

Continued on next page

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:

Anthem Blue View Vision
ATTN: Appeals
P.O. Box 9304
Minneapolis, MN 55440-9304
Telephone Number: 855-556-4844

The Appeals unit 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 stated 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.

Get Help in Your Language

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

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

Amharic

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

Arabic

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

Chinese

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

Farsi

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

French

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

German

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

Gujarati

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

Haitian

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

Hindi

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

Japanese

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

Korean

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

Portuguese-Europe

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

Russian

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

Vietnamese

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

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.