Vision Certificate of Coverage

Blue View Vision

Georgia Municipal Employees Benefit System (GMEBS)

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.

Anthem Blue Cross and Blue Shield
Corporate Headquarters
3350 Peachtree Rd
Atlanta, GA 30326

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

The Plan Sponsor, Georgia Municipal Employees Benefits System, has the following documents which are part of the terms of your *plan*:

- the *group contract*; and
- the group master application.
- your employer/s Vision Participation Agreement

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 italicized words have special meanings that are defined in the Definitions section of this *certificate*.

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

Jeff Fusile
President

Contact Us

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

For Customer Service

Anthem Blue Cross and Blue Shield
P.O. Box 8504
Mason, OH 45040-7111
(866) 723-0515

Visit us on-line

www.anthem.com

Hours of Operation

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

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

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Schedule of Benefits

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

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

COVERED SERVICES	**COPAYMENTS/MAXIMUMS**	
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
Eye Exam Limited to one exam per every calendar year	$10 copayment	Reimbursed up to $35
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 every calendar year **Basic Lenses (Pair)** In addition to contact lenses		
• Single Vision lenses	$10 copayment	Reimbursed up to $25
• Bifocal lenses	$10copayment	Reimbursed up to $40
• Trifocal lenses	$10 copayment	Reimbursed up to $55
• Lenticular lenses	$10 copayment	Reimburse up to $55
Frame Limited to one set of frames per member every calendar year	$180 allowance	Reimbursed up to $70
Prescription Contact Lenses (traditional or disposable) In lieu of eyeglass lenses		
• **Non-Elective Contact Lenses** Availability once every calendar year	Covered in full	Reimbursed up to $200
• **Elective Contact Lenses** Availability once every calendar year	$180 allowance	Reimbursed up to $85

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.

Eligibility and Enrollment

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

Who is Eligible

Subscriber. You are eligible to be a subscriber and have coverage under this plan if you are an employee of the group and meet the group's eligibility criteria.

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

- Spouse: Your spouse under a legally valid marriage.
- Children: Your or your spouse's child by blood or by law up to age 26. This includes your natural children, stepchildren, legally adopted children, children placed for adoption, foster children or children for whom you are the legal guardian or have been court-ordered to provide coverage.

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

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

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

Enrollment

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

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

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

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

Qualifying events are:

- You or your *dependents* did not previously enroll for coverage because you had coverage under another group plan (including COBRA or other continuation coverage) and have since become ineligible for that plan. You must request enrollment within 31 days of this qualifying event.
- You have a change in the number of *dependents* due to marriage, birth, adoption, court order, legal guardianship, or death. You must request enrollment within 31 days of this qualifying event.
- You or your *dependents* lost coverage under Medicaid or a Children's Health Insurance Program (CHIP), or became eligible for a subsidy (state premium assistance program) under Medicaid or CHIP. You must request enrollment within 60 days of this qualifying event.

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

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

Statements and Forms

Subscribers (or applicants for membership) must complete and submit applications, medical review questionnaires, or other forms or statements the plan may reasonably request.

Applicants for membership understand that all rights to benefits under this certificate are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by a member may result in termination of coverage as provided in the: Termination and Continuation of Coverage section. We will not use a statement made by a member to void the member's contract after coverage has been in effect for two (2) years. This does not apply, however, to fraudulent misstatements.

Delivery of Documents

We will provide an identification card for each subscriber. The Plan Sponsor will provide a certificate to your employer for delivery to you.

Termination and Continuation of Coverage

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 Your Group Cancels Coverage. Your coverage will end if your employer cancels coverage or on the date the *Vision Participation Agreement* ends.

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

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

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

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

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

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

Continuation of Coverage

COBRA Continuation of Coverage. COBRA allows you and your dependents to continue coverage for either 18, 29 or 36 months depending on the event.

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

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

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

- You or your dependent was disabled when coverage ended or within 60 days after the coverage ended. However, you or your dependent must continue to be disabled after 18 months has passed.

The Social Security Administration must determine if you are disabled.

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

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

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

How Continuation of Coverage Ends

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

- The *vision participation agreement* ends or *the master group contract* with the *plan sponsor* ends. If your employer switches coverage you will be able to continue coverage under their new plan.
- You fail to pay the premium.
- You tell us in writing to cancel your coverage.
- The date your spouse remarries and becomes eligible under the new spouse's plan.

Coverage may also end for COBRA if the following occurs:

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

How Your Benefits Work

This section tells you how we pay for your vision care. It will also tell you more about how your out of pocket costs are determined, and how your choice of *provider* may affect those out of pocket costs. The Schedule of Benefits will tell you the specific amounts for which you are responsible to pay for your vision care.

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

> **Important Note:** We do not restrict or interfere with your right to select the *provider* of your choice, but your benefits may be reduced when you use a *provider* who is not a *network provider*. Please call us or visit our website listed in the Contact Us section if you want help in finding a *network provider*.

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

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

Non-Network Providers. *Non-network providers* are vision care *providers* that did not agree to participate in our Blue View Vision network. They have not agreed to any negotiated rate and do not have a provider contract with us. *Non-network providers* can charge you their usual amount for *covered services*. As such, using a *non-network provider* will typically increase your out of pocket costs.

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

Benefit Maximums, Allowances and Frequency Limits

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

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

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

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

Covered Services

This section describes the covered services available under your vision care benefits. 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.

Routine Eye Exam. Your plan covers a complete routine eye exam with dilation, as need. The exam is used to check all aspects of your vision. An eye exam does not include a contact lens fitting fee.

Eyeglass Lenses (in addition to contact lenses). You have a choice in your eyeglass lenses. Eyeglass lenses include factory scratch coating at no additional cost. Your dependent children under 19 may also receive polycarbonate and photochromic eyeglass lenses at no additional cost when received from a network provider.
Covered eyeglass lenses include plastic (CR39) lenses up to 55 mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- lenticular

Frames. You have a benefit allowance towards your choice of frames. You may apply the allowance toward the purchase of any frame. If your frame choice is more than your allowance, then you are responsible for the balance. The Schedule of Benefits lists your allowance and benefit frequency.

Contact Lenses (in addition to eyeglass lenses). This plan covers elective or non-elective contact lenses. You may receive a benefit for elective contact lenses or non-elective contact lenses, but not both.

Elective Contact Lenses. Elective contact lenses are contacts that you choose for appearance or comfort.

Non-Elective Contact Lenses. Non-elective contact lenses are prescribed by your provider for diagnoses listed below:

- 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

Important 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.

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

Exclusions

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

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

How to Submit a Claim

This section describes how you submit a claim and what information you should include on your claim. When you receive care from a *network provider*, you do not need to file a claim. The *network provider* will do this for you. However, if you receive vision care from a *non-network provider*, you will need to submit a claim to us.

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

Claim Forms. Once you give us notice of your claim, we will provide you with the claim forms you will need within 15 days after you notify us. The claim form will have instructions on how to fill it out and where to send it to us. If you do not receive the claim form within 15 days of your notice, you may send us other written proof of your loss instead. An example of other proof of loss would be an itemized bill from your *provider*. To make it easier to process your claim, the other proof of loss should include the following:

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

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

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

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

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

General Provisions

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

Entire Contract-Changes. Your *plan* is the entire contract of insurance. Your *plan* is made up of this *certificate*, the *group contract*, the *group's* and, if any, your applications. In addition, the *plan sponsor* has the master group contract and the group master application, both of which are also part of your plan, and your employer has the *vision participation agreement.* No agent or employee of the *plan* is authorized to change the form or content of this *plan* or waive any of its provisions. All statements made by you or the *group* shall be deemed representations and not warranties. No written statement made by you will be used in any contest for a claim unless a copy of the statement is furnished to you, or to your beneficiary or personal representative.

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

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

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

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

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

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

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

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

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

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

Legal Action. No action at law or in equity shall be brought to recover on this *plan* prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this *plan*. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

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

Complaints and Appeals

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

Complaints

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

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

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

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

Appeals

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

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

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

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

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

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

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.

Allowance. A dollar amount available to apply towards materials or services.

Calendar Year. The period of time that benefits are tracked. 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 summary of the terms of your benefits. It is attached to and is a part of the master group contract and is subject to the terms of the master group contract.

Copayment. A specific dollar amount for covered services 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 service, supply or treatment must be:

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

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

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

Effective Date. The date when your coverage begins under this plan.

Group. The employer that has entered into a vision participation agreement with us to provide the benefits of the plan**.**

Master Group Contract. The contract between the *plan sponsor* and us. It includes this certificate, the Plan Sponsor's application, any supplemental application or change form and any endorsements or riders.

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, 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.”

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

Plan Sponsor. Georgia Municipal Employees Benefit System (GMEBS). GMEBS is the plan sponsor of this coverage because it has entered in the master group contract with us.

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

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

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

Subscriber. An eligible employee or member of the group who is eligible to receive benefits under this plan.

Vision Participation Agreement. The agreement between your employer and the *plan sponsor t*hat sets forth eligibility requirements and waiting periods. Your employer must enter into a *vision participation agreement* in order to offer this vision coverage

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 मुफ़्त 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.