Anthem Health Plans of Virginia, Inc. d/b/a
Anthem Blue Cross and Blue Shield
Corporate Headquarters
2015 Staples Mill Road
Richmond, VA 23230

Anthem Blue Cross and Blue Shield
Blue View Vision Member Certificate for Large Group

Blue View Vision
EX.A.15

This Company is subject to regulation in this Commonwealth by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and by the Virginia Department of Health pursuant to Title 32.1.

VAGRPVISION 0118

Welcome!

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

- this booklet (your *certificate*);
- your application, if any; and
- any endorsements or riders.

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

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

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

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

Please review this booklet 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.

Jeff Ricketts
President

IMPORTANT NOTE: You have been enrolled in this vision *plan* by your employer. If you (the *subscriber*) and/or your *dependents* did not complete an enrollment form for this coverage, this *plan* is not contestable.

Contact Us

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

For Customer Service

Anthem Blue 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

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

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

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact either of the following offices for assistance:

Office of the Managed Care Ombudsman
Bureau of Insurance P.O. Box 1157 Richmond, VA 23218
Toll-free phone: 1-877-310-6560
Richmond Metro Area: 1-804-371-9032
E-Mail: ombudsman@scc.virginia.gov

Center for Quality Health Care Services and Consumer Protection
3600 W. Broad Street, Suite 216 Richmond, VA 23230
Toll free phone: (800) 955-1819
Richmond Metro Area: (804) 367-2106
Website: www.vdh.state.va.us

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Table of Contents

Schedule of Benefits

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

Vision Care Services	Benefit Frequency	In-Network	Out-of-Network Reimbursement
Routine Eye Exam	Once every Calendar year	$15 Copay	Reimbursed Up to $30

Eligibility and Enrollment

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

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

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

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

Enrollment

Initial Enrollment. Your *group* will have an initial enrollment period for newly eligible employees or other members of the *group* 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 us of any changes according to the terms of the *group contract*. If your *group* fails to notify us of your changes in eligibility, it does not obligate us to pay for your vision care.

Your Effective Date

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

TERMINATION AND CONTINUATION OF COVERAGE

Termination

This section explains how your coverage may end. Upon your *group's* anniversary date, this coverage will renew at the option of the *group*, as long as premiums are paid. Unless otherwise stated in this section, any notice of cancellation or nonrenewal will be delivered to your *group*.

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

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

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

Fraud or Misrepresentation. We will cancel this coverage if there are fraudulent misstatements in your application (if any) or the *group's* master application.

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

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

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

Continuation of Coverage

COBRA Continuation of Coverage. Your employer is subject to COBRA if they have more than 20 employees. COBRA allows you and your dependents to continue coverage for either 18, 29 or 36 months depending on the event.

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

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

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

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

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

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

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

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

- The Group Contract between us and the employer ends. If your employer switches coverage you will be able to continue coverage under their new plan.
- You fail to pay the premium.
- 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.]

Conversion Coverage
Conversion is not available under this *plan*.

How Your Benefits Work

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

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

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

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

IMPORTANT: If you opt to receive optometric services or procedures that are NOT *covered services* under this *plan*, a *network provider* may charge you his or her usual and customary rate for such services or 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 network. They have not agreed to a negotiated rate and do not have a provider contract with us. Using a *non-network provider* will typically increase your out of pocket costs. *Covered services* you receive from *non-network providers* are considered Out-of-Network care.

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

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

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

The following services or supplies are covered subject to our Conditions of Service. We will only pay for vision care that is listed in this section. We will not pay for vision care listed in the Exclusions section. See your Schedule of Benefits for more information on your allowances and your benefit frequencies.

Routine Eye Exam. Your *plan* covers a complete eye exam with dilation as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Exclusions

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

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

How to Submit a Claim

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

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

Claim Forms. We will provide claim forms within 15 days after you notify us. The claim form will have instructions on how to fill it out and where to submit. If you do not receive a claim form within 15 days of your claim notice, you may send us an itemized bill instead. The itemized bill should include the following:

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

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

Notice of claim, claim forms and 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 60 days after we receive your proper written proof of loss.

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

General Provisions

Entire Contract – Changes. Your *plan* is the entire contract of insurance. Your *plan* is made up of this *certificate*, your application (if any), and any amendments. In addition, your employer has the *group contract* and the group master application, which are also part of your *plan*. An executive officer must endorse any change that we issue for it to be valid. No agent has authority to change this *plan* or to waive any of its provisions. All statements made by you or your employer shall be deemed representations and not warranties. No written statement made by you will be used in any contest 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 your or your *dependents*.

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

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

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

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

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

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

Conformity to the Law. The laws of the Commonwealth of Virginia will be used to interpret any part of this *plan*.

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

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

Modifications. We may change this plan, including the premiums, at any time by providing notice to the *group* at least 60 days before the change takes effect.

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

Claims Experience

Upon employer request, we will provide a complete record of claims experience. This record shall be made available promptly to the policyholder upon request made not less than 30 days prior to the date upon which the premiums or contractual terms of the policy, contract or plan may be amended.

COMPLAINTS AND APPEALS

This section will tell you how to contact us when you have questions, suggestions, concerns, or complaints.

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.

If you have a concern about the quality of care offered to you by a *network provider*, such as waiting times or *provider* demeanor, we encourage you to discuss your concerns with the *provider* directly before you contact our customer service.

Appeals
If you do not agree with a claim denial made by us, you have a right to a full and fair review. 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
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.

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

Statement of ERISA Rights

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

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

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

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

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

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

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

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

Definitions

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

Certificate. This booklet, which is a summary of the terms and conditions of the benefits of this *plan*. It is attached to and is a part of the *group contract*. It is also subject to the terms of the *group contract*.

Copay or Copayment. A fixed dollar amount that you are responsible to pay for *covered services*. See the Schedule of Benefits for your copay amounts.

Covered Services. Services, supplies or treatments that are listed as in the Covered Services section of this *certificate*. A covered service is incurred on the date the service, supply or treatment was provided to you. To be considered a covered services, the service 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 listed as a benefit within this *certificate*.

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 your coverage begins under this *plan*.

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

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

Maximum Allowable Amount. This is the maximum amount we will pay for *covered services*. It is based on our established network fee schedule. See the How Your Benefits Work section for more information on how we determine the maximum allowable amount.

Member. Any person (*subscriber* or *dependent*) enrolled for coverage under this *plan*.

Network Provider. A *provider* who has entered into a contractual agreement with us for the network associated with this *plan*. They also accept our payment plus your cost-share as payment in full for *covered services*.

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

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

Provider. A duly licensed person or facility that provides vision services within the scope of an applicable license.

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

Get Help In Your Language

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).

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

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

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)

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

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)

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)

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

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

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

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

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.