Anthem Blue Cross and Blue Shield Vision Certificate of Coverage

Blue View Vision B3

Anthem Health Plans, Inc. dba
Anthem Blue Cross and Blue Shield
Corporate Headquarters
108 Leigus Road
Wallingford, CT 06492

INTRODUCTION

Welcome!

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

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

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

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

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

CONTACT US

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

Visit us on-line
www.anthem.com

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

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

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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*. No prior authorization is required to receive covered vision services.

BENEFIT PERIOD	calendar year
DEPENDENT AGE LIMIT	dependent children are covered to the end of the month in which the child turns 26

Vision Care Services	Benefit Frequency	In-Network	Out-of-Network Reimbursement
Routine Eye Exam	Limited to one exam per member every calendar year	$10 copayment	reimbursed up to $48
Standard Plastic Lenses†	Limited to one set of lenses per calendar year		
• Single Vision lenses		$10 copayment	reimbursed up to $36
• Bifocal lenses		$10 copayment	reimbursed up to $54
• Trifocal lenses		$10 copayment	reimbursed up to $69
†Lenses include factory scratch coating, polycarbonate lenses for children under 19 years old and Photochromic lenses for children under 19 years old at no extra cost when received from Network Providers.			
Frames	Limited to one frame per two calendar years	$130 allowance	reimbursed up to $64
Prescription Contact Lenses	Limited to once per calendar year		
Non-Elective Contact Lenses		covered in full	reimbursed up to $210
Elective Contact Lenses (traditional or disposable)		$130 allowance	reimbursed up to $105
Note: You may receive a benefit for non-elective or elective contact lenses, but not both. Also, contact lenses are in lieu of your eyeglass lenses benefit. If you elect covered non-elective contact lenses or elective contact lenses within a stated benefit period, no benefits will be available for covered lenses until the next benefit period.			

ELIGIBILITY AND ENROLLMENT

Who is Eligible

Subscriber. To be eligible to enroll as a *subscriber* you must:

- be an employee of the *group*:
- meet the eligibility criteria established by the group and stated in the group contract;
- be entitled by the group to participate in the group's benefit plan.

Dependents. Your following family members may be eligible to enroll as dependents under this plan:

- Your legal spouse.
- Your domestic partner. See your group for more information on domestic partner coverage. All references to spouse in this certificate will apply to domestic partners, as well.
- Your children. Your children and your spouse's children up to the age limit stated in the Schedule of Benefits. A dependent child may be your natural children, step-children, adopted children, or children for whom you have been appointed the legal guardian or for whom you have been court ordered to provide coverage.

  Dependent children may continue coverage beyond the age limit when:
  - they are unmarried and cannot sustain employment due to a physical or mental disability (as certified by a physician);
  - are chiefly dependent on you or your spouse for support and maintenance;
  - were enrolled and disabled prior to reaching the limiting age of this plan.

  Proof acceptable to us of such disability and dependency must be received within 31 days of the date upon which the child's coverage would have terminated in the absence of such disability. We may require continued proof of the disability, but no more than annually after the two year period from when the dependent child reaches the age limit of this plan.

Newborn and Adopted Children. Your or your spouse's newborn or adopted child 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 us within 31 days of the date of birth, placement for adoption, or adoption to add them to this plan.

Enrollment

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

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

Open Enrollment. Open enrollment is the period of time during which eligible persons and their *dependents* can apply for or change their coverage. Open enrollment happens only once per year. See your *group's* human resources or benefits department for more information on open 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 *dependents* can enroll for coverage outside of open enrollment period. This is allowed if you have certain qualifying events happen. Qualifying events are:

- You or your *dependents* did not enroll for coverage because you had coverage under another group plan and have since become ineligible for that plan. You must request enrollment within 31 days after this qualifying event.
- You or your dependents lost coverage under Medicaid or a Children's Health Insurance Program (CHIP); or become eligible for a subsidy (state premium assistance program under Medicaid or CHIP. You must request enrollment within 61 days after this qualifying event.
- You have a change in *dependents* due to marriage, birth, adoption, court order, legal guardianship or death. You must request enrollment within 31 days after this qualifying event.

Notice of Eligibility 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*. If your *group* fails to notify us of your changes in eligibility, it does not obligate us to pay for your vision care.

Returning from Military Service. If you return from full-time active service following a call to active military duty, no waiting period applies. You and your *dependents* can reenroll in this coverage, as long as you apply for reemployment within the time period allowed by the Uniformed Services Employment and Reemployment Act. The time period allowed for reemployment depends on the length of your active military duty. To reenroll in the *plan*, you must request re-enrollment within 31 days of your reemployment date. Coverage will be effective on the effective date of your reemployment.

Effective Date

Your *effective date* and other enrollment requirements are described in the *group contract*. See your *group* for more information on your *effective date* under this *plan*.

A *member's* coverage terminates on the date such *member* ceases to be in a class of *members* eligible for coverage. We have the right to bill you (the *subscriber*) for the cost of any services provided to you or your *dependents* during the period such person was not eligible under this coverage.

Statements and Forms. You must complete and submit any necessary applications, or other forms or statements, we may reasonably request. You agree that to the best of your knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to us is true, correct, and complete. You also understand that all rights to benefits under this *certificate* are subject to the condition that all such information is true, correct and complete. During the first two years following the *effective date* of the *plan*, any material misrepresentation by a *member* may result in termination of coverage as provided in the Termination and Continuation of Coverage section.

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 their option, as long as *premiums* are paid. Unless otherwise stated in this section, written notice of cancellation or nonrenewal will be delivered to your *group* within 30 days of cancellation. Except noted otherwise below, coverage will end on the last day of the month in which the event occurs.

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

If You Cancel Your Coverage. If you want to cancel your or your dependents 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, such as when you are no longer an employee or other member of the *group*, or a dependent reaches the limiting age of the *plan*. See the Eligibility and Enrollment section for eligibility requirements. If you (the *subscriber*) lose coverage because you are no longer eligible, your dependents will also lose coverage. Your *group* will determine the date your coverage ends once you lose eligibility. See your *group's* human resources or benefits department for more information.

If Your Group No Longer Meets the Requirements of the Group Contract. You coverage will end if your *group* no longer meets the requirements of the *group contract*. For example, if the *group* no longer is able to meet the participation requirements of the *plan*.

Fraud or Misrepresentation. We will cancel this coverage if you give us any fraudulent misstatements (false information) about your eligibility during the application and enrollment process. Coverage will end on the date we send written notice of cancellation. However, after two years following the *effective date* of this plan, we will not use any statements made on your application to void or deny your coverage.

If Your Employer Does Not Pay the Premium. We 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 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 Connecticut.

Grace Period. Your group has a 31 day grace period to pay premiums. During the grace period, this coverage stays in force. The group is responsible to pay premiums on your behalf. You may be required to pay the group a portion of the premium. See your group's human resources or benefits department for more information on premiums. If the *group* does not pay the premium within the grace period, this coverage will end on the last date for which *premiums* have been paid. Coverage may be reinstated, but a reapplication may be necessary. See the Reinstatement provision below for more information. We will not be liable to pay for any vision care services you receive after the period for which the *premium* was paid. The group or you will be responsible to pay for any services received.

Reinstatement. If coverage lapses because the *premium* was 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 due to the *group's* clerical error. However, the *group* is liable to us if we incur financial loss as a result of their clerical error.

Conversion. Conversion coverage is not available under this Certificate.

Continuation of Coverage

Federal Continuation of Coverage (COBRA). You may continue this coverage if your coverage ends because of any of the following qualifying events listed in the grid below. If you are eligible for continuation coverage, you are considered a qualified beneficiary. To continue coverage, you must be covered under this *plan* before the qualifying event happens. In all cases, continuation ends if the *group contract* terminates or *premiums* are not paid when due.

Qualifying Event	Who May Continue	Maximum Continuation Period
Employment ends, retirement, leave of absence, or reduction in hours (except gross misconduct dismissal)	Subscriber and dependent	Earliest of: 1. 18 months, or 2. enrollment date in other group coverage or Medicare, or 3. date coverage would otherwise end.
Divorce or legal separation or dissolution of domestic partnership	Former spouse and dependent children	Earliest of: 1. 36 months, or 2. enrollment date in other group coverage or Medicare, or 3. date coverage would otherwise end.
Death of the subscriber	Surviving spouse and dependent children	Earliest of: 1. 36 months, or 2. enrollment date in other group coverage or Medicare, or 3. date coverage would otherwise end.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, or 2. enrollment date in other group coverage or Medicare, or 3. date coverage would otherwise end.
Total Disability of subscriber	Subscriber and dependents	Earliest of: 1. 29 months after the subscriber leaves employment, or 2. date total disability ends, or 3. enrollment date in other group coverage or Medicare, or 4. date coverage would otherwise end.
Employee leaves for duty in the military service	Subscriber and dependent	Earliest of: 1. The 24 months continuation 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.

If Your Group Offers Retirement Coverage. If you are a retiree under this *plan*, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your *group*, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your *dependents* will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this *plan*. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her *dependents* may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Connecticut Continuation Rights. Continuation options will be provided under each of the following circumstances for the period indicated or until the *member* becomes eligible for other group insurance, except as otherwise stated in this section.

A. The *group* may allow a *member* and their *dependents* who become ineligible for continued participation under this *plan* to elect to continue coverage as described below.

   i. Upon termination of the *member's* employment, other than as a result of death or the gross misconduct of the *member*, the *member* and his or her *dependent* may continue coverage until the end of 18 months following the day on which he or she ceased to be eligible for coverage under this *plan*;

   ii. Upon the *member's* death, his or her *dependent* may continue coverage until the end of 36 months following the day on which they ceased to be eligible for coverage under this *plan*;

   iii. Upon dissolution of the *member's* marriage, his or her *dependent* may continue coverage until the end of 36 months following the day on which they ceased to be eligible for coverage under this *plan*.

B. Upon the *member's* absence from employment due to illness or injury, a *member* and his or her *dependents* may continue during the course of such illness or injury or for up to 12 months from the beginning of such absence.

C. Upon termination of the *plan* by the *group* or us, benefits for *covered services* for a *member* who was Totally Disabled (as determined by Title II or Title XVI of the Social Security Act) on the date of termination shall be continued without premium payment during the continuance of such disability for a period of 12 months following the month in which the *plan* was terminated, provided the claim is submitted within one year of termination of the *plan*.

D. An additional 11 months shall be available to a *member* and an enrolled *dependent* who is; determined to be disabled under Title II or Title XVI of the Social Security Act at the time he or she becomes eligible for extended continuation of coverage under Connecticut Continuation Rights, or becomes disabled at any time during the first 60 days of Connecticut Continuation Rights coverage. The *member* or enrolled *dependent* must provide notice of the disability determination to us not later than 60 days after the date of the Social Security Administration's determination, and before the end of the initial 18 months of Connecticut Continuation Rights coverage.

E. A *member* is required to provide timely notice to the *group* of his or her election to continue coverage. Except as provided in (C) above, a *member* who continues coverage may be required to remit the applicable premium payment to the *group*. Payment of such premiums need not be made on behalf of the *member* by the *group* if they are not received by the *group* on a timely basis. Failure of the *member* to remit such premium may result in termination.

Who May Elect to Continue Coverage. Qualified beneficiaries are eligible to elect to continue coverage. Qualified beneficiaries are individuals who had coverage under the *plan* immediately prior to the qualifying event and are either covered *subscribers* or *dependents*. A qualified beneficiary also includes a child born to or placed for adoption with the subscriber during the continuation period.

Choosing Continuation. Once you tell the group about a qualifying event, the *group* must notify you of your option to continue coverage within 10 days. If you choose to continue coverage you must notify the *group* in writing. You have 60 days to elect to continue coverage, starting with the date of the notice of continuation or the date coverage is terminated, whichever is later. If you do not choose continuation within the required time period will make you ineligible to choose continuation at a later date.

Paying for Continuation Coverage. You have 45 days from the date of electing continuation to pay the first charge for continuation. After this initial period, you must pay charges monthly in advance to your *group* to keep your coverage in force. Failure to pay charges within 30 days of the due date will result in termination of coverage. Charges for continuation are the group rate plus a 2% administrative fee. If the Group Member's total disability was the qualifying event for continuation, the cost to continue coverage could be the group rate plus a 2% administrative fee.

Social Security Determination for Total Disability. If the you or your *dependent* is Totally Disabled at the time you (the *subscriber*) leaves employment, or becomes disabled within the first 60 days of continuation of coverage, an additional 11 months will be available to you and your enrolled *dependents*. In order to qualify for this extension, the individual must be determined to be disabled under Title II or Title XVI of the Social Security Act at the time they became eligible for extended continuation of coverage under continuation, or became disabled at any time during the first 60 days of continuation coverage. Your or your enrolled *dependent* must provide notice of the disability determination to us not later than 60 days after the date of the Social Security Administration's determination, and before the end of the initial 18 months of continuation coverage.

If it is determined that the individual is no longer disabled, the extended continuation of coverage period can be terminated on the first of the month following 30 days after the final determination notice.

Special Continuation Rights for Totally Disabled Members When Group Contract Terminates. Upon termination of this coverage by the *group* or Anthem, benefits for *covered services* for a *member* who was Totally Disabled on the date of termination shall be continued for up to 12 months without *premium* payment. The claim must be submitted within 12 months of the termination of this coverage.

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 coverage for yourself and your *dependents* under this *plan* in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

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

You may elect to continue to cover yourself and your *dependents* under this *plan* and upon payment of any required premium for coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active employee contribution, if any, for continuation of health coverage. If continuation is elected under this provision, the maximum period of coverage under this *plan* shall be the lesser of:

- The 24 months beginning on the first date of you absence from work; or
- The day after the date on which you fail to apply for or return to a position of employment.

Regardless whether you continue your coverage, if you return to your position of employment, your coverage and that of your *dependents* will be reinstated under this *plan*.

HOW YOUR BENEFITS WORK

This section tells you how we set the payment amount for vision care. It will also tell you more about what you pay for vision care, as well as how your choice of *provider* may affect your out of pocket costs. The portion you must pay for vision care services is stated in the Schedule of Benefits in 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 *participating 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 provided 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 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 booklet.

Your Cost Share Requirements

You may be required to pay a part of the *maximum allowable amount* for *covered services*. 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 *policy*. 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 tells you more about the vision care services that are covered in this *plan*. 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 the Schedule of Benefits for your copayments, allowances, and benefit frequencies.

Note: Your out-of-pocket costs may be higher if you receive vision care from a non-network provider. See your Schedule of Benefits for more information on your allowances and your benefit frequencies. For help finding a network provider, contact us at the phone number or visit us at the website listed under the Contact Us section at the beginning of this booklet.

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. An eye exam does not include a contact lens fitting fee.

Eyeglass Lenses. You have a choice in your eyeglass lenses. Eyeglass lenses include factory scratch coating when received from a *network provider*. Your dependent children under 19 may also receive polycarbonate and photochromic lenses at no additional cost when received from a *network provider*. If you choose other coatings, lens materials and treatments that are not listed as covered under in this *certificate*, you will be responsible to pay all charges for those items. Covered lenses include plastic (CR39) lenses up to 55mm in:

- single vision
- bifocal
- trifocal (FT25-28)

Frames. You have a benefit allowance to apply towards your choice of frames. You may apply the allowance toward the purchase of any frame. If the frame you pick is more than your allowance, then you are responsible to pay for the difference.

Contact Lenses. This plan covers a selection elective or non-elective contact lenses. You may receive a benefit for elective contact lenses or non-elective contact lenses, but not both. Benefits for contact lenses are in lieu of your eyeglass lens benefit. If you receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.

Elective Contact Lenses. You have a benefit allowance to apply towards elective contact lenses. If you pick contact lenses that are more than your allowance, then you are responsible to pay for the difference.

Non-Elective Contact Lenses. Non-elective contact lenses are contacts that may be prescribed to you for certain eye conditions. Non-elective contact lenses are covered when the following conditions have been identified or diagnosed:

- For members whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses;
- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses;
- High Ametropia exceeding -12D or +9D in spherical equivalent; or
- Anisometropia of 3D or more.

Special Note: We will not reimburse for non-elective contact lenses for any member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

EXCLUSIONS

The following section indicates items, which are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items, which 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 benefits.

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

- **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.
- **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.

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

PO Box 8504
Mason, Ohio 45040-7111
Phone: (866) 723-0515

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

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

GENERAL PROVISIONS

Entire Contract. Your *plan* is entire contract of insurance. Your plan is made up of this *certificate*, the *group contract*, the *group* application, your application (if any) and any riders, endorsements or amendments. No agent has the authority to change this plan or waive any of its provisions. An executive officer must endorse any change that we issue for it to be valid. All statements made by you or your *group* shall be deemed representations and not warranties. No written statement made by you will be used in any contest for a claim unless a copy of the statement is furnished to you, or to your beneficiary or personal representative.

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.

Circumstances Beyond the Control of the Plan. In the event of circumstances not within our control (including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within our control, disability of a significant part of a *network provider's* personnel or similar causes) or the rendering of vision care services provided under this *certificate* is delayed or rendered impractical, we will make a good-faith effort to arrange for an alternative method of providing coverage. In such event, we and *network providers* will render services provided under this *certificate* as is practical, and according to their best judgment. Neither we nor *network providers* will incur any liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

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

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

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*.

Conformity with State Law. The laws of the State of Connecticut will be used to interpret any part of this *plan*. Any provision of this *plan* which is in conflict with the laws of the State of Connecticut will be amended to conform to 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.

Clerical Error. If we or the group makes a clerical error in keeping any record regarding this coverage, it will not invalidate your coverage.

Vision Examination. We, or anyone acting on our behalf, has the right to have a *provider* examine you as often as is reasonably required while we, or anyone acting on our behalf, are processing a claim. You will be notified in advance of any such examination.

Notice of Privacy Practices. We promise to protect the private nature of your health information to the fullest extent of the law. In additional 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*.

Vision Services. We are not liable for providing *covered services*, but merely for the payment of them. You will have no claim against us for any acts or omissions of a *provider* that you receive *covered services* from. We have no responsibility if a *provider* fails or refuses to give *covered services* to you.

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.

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.

HOW TO SUBMIT AN APPEAL

This section will tell you how to contact us when you have questions, suggestions, concerns or complaints. Our customer service representatives are specially trained to answer your questions about our vision benefit plans. Please call at the number provided in the Contact Us section near the front of this booklet with questions regarding:

- your coverage and benefit levels, including copayments or 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 your claim or other request for benefits is denied, the notice of denial will explain it was denied and tell you your rights under our appeals procedure. A complaint procedure also exists to help you understand our decisions made when processing your claims.

The Complaint Procedure

The complaint procedure is a resource that provides reasonable, informative responses to complaints that you may have about the *plan*. A complaint is an expression of dissatisfaction that can often be resolved by an explanation of the terms and conditions of your plan. We invite you to share any concerns that you may have about our decision in your claims or your coverage and benefit levels.

If you have a complaint or problem concerning benefits or services, please contact us. You may submit your complain by letter or by telephone. You are encouraged to file your complaint within 60 days of the initial, adverse action, but must file no later than 6 months after the initial 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 asking us to change the decision of a claim or benefit determination. If you are notified in writing that we denied your claim, or any other adverse decision by us, you will be advised of your right to an internal appeal.

The appeals process may be initiated by you, your authorized representative, or a provider acting on your behalf. We encourage appeals to be submitted to us within 60 days after your receive our written notice that we denied your claim, but must be filed no later than six months. The request should include any information or documents you feel would be important in our decision of your appeal. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of any documents, records or other information relevant to your appeal.

The individuals responsible for reviewing your appeal will not be the same individuals who made the initial decision in your claim or benefit determination. Nor will they be subordinates of the initial decision makers 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 you or your authorized representative a written decision.

Your request for an internal appeal must be submitted to the following address or telephone number:

Blue View Vision
Attention: Appeals
555 Middle Creek Parkway
Colorado Springs, CO 80921
Telephone Number: 866-723-0515

Authorized Representative. If you would like to designate an authorized representative to submit an appeal on your behalf, we must receive your request in writing. Contact member services at the number in the Contact Us section for more information on how to designate an authorized representative. You do not need to send us notice if your *provider* is submitting the appeal on your behalf.

DEFINITIONS

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

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*.

Copayment (or copay). A fixed 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 treatments 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. 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*; and
- specifically listed as a benefit within this *certificate*.

Creditable Coverage (proof of prior coverage). The term Creditable Coverage means health coverage provided through an individual policy, a self-funded or fully insured group health plan offered by a public or private employer, Medicare, Medical Assistance, General Assistance Medical Care, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Federal Employees health Benefit Plan (FEHBP), Medical Care Program of the Indian Health Service of a tribal organization, a state health benefit risk pool, a State Children's Health Insurance Program (S-CHIPS), a qualified Public health Plan or a Peace Corp health plan.

Dependent. A member of the *subscriber's* family that may be covered under this *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 that has entered into a *group contract* with the *plan***.**

Group Contract. The contract between the Anthem and the *group*. It includes this *certificate*, your and the *group's* applications (if any), and any endorsements or riders.

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 the maximum allowable amount.

Member. Any person (*subscriber* or *dependent*) who has applied for and been accepted by us for coverage under this *plan*.

Network Provider. A vision care *provider* who has entered into a contractual agreement with us for the network associated with this *plan*. They have agreed to accept our payment and your cost-share, if any, as payment in full for *covered services*.

Non-Network Provider. A vision care *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 vision coverage. It consists of this *certificate*, your and the *group's* applications (if any), the *group contract*, and any endorsements or riders.

Premium. The periodic charges that the *group* must pay us to maintain coverage under this *plan*. You may be responsible to pay a portion of the premium. See your *group* for more information about premiums.

Provider. A duly licensed person or facility that provides 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*.

DOMESTIC PARTNER COVERAGE RIDER

Definition

The definition of Domestic Partnership for this rider shall be two individuals, of the same or opposite sex, that live together in a long-term relationship of indefinite duration with an exclusive mutual commitment in which the Domestic Partners ("Partners (s)") agree to be jointly responsible for each other's common welfare and share financial obligations.

Eligible Groups

A. All employer groups that meet the eligibility requirements for group coverage of Anthem Blue Cross and Blue Shield (Anthem BCBS) may request Domestic Partner coverage.

B. The employer group's contribution schedule must remain neutral with respect to Domestic Partner coverage.

Domestic Partner Eligibility Criteria

Domestic Partner eligibility between two persons of the same or opposite sex exist when all the requirements identified in A, B, C and D below are satisfied:

A. Domestic Partners must meet all of the criteria below:

- Each party is the sole Domestic Partner of the other.
- Each party is at least eighteen (18) years of age.
- Both parties currently share a common legal residence and have shared said residence for at least 12 months prior to application for Domestic Partner coverage.
- Domestic Partners must be jointly responsible for basic living expenses.
- Both parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future.
- Neither party is married to another person.
- Neither party is related to the other by adoption or blood to a degree of closeness that would bar marriage in the state in which they reside, except for those states that legally recognizes Domestic Partners as a legal valid marriage.

B. Domestic Partners must have in effect and provide proof of any one of the following:

- Designation of Domestic Partner as beneficiary for life insurance and retirement contract; or
- Designation of Domestic Partner as primary beneficiary in the (Covered Person's) will; or,
- Documentation by one Partner designating the other partner as his/her agent for:

  Personal relationship issues, or
  Health care decisions, or
  Health Care agent.

C. Neither party has filed a Termination of Domestic Partnership within the preceding 12 months.

D. To enroll an eligible Domestic Partner, both the Covered Person and the Domestic Partner must complete and sign the Anthem BCBS Statement of Domestic Partnership. Signatures must be witnessed and notarized by a notary public. Anthem BCBS reserves the right to make the ultimate decision in determining eligibility of the Domestic Partner.

Dependent Eligibility

Dependent children of the Covered Person and/or Partner are eligible for benefits for covered services if the following requirements are satisfied:

A. The child(ren) is/are primarily dependent upon the Covered Person and/or Partner for support and a parent-child relationship exists between the Covered Person and child(ren) based on all of the conditions as set forth in a, b, c and d below being met:

- the child(ren) must be unmarried and reside in the same household as the Covered Person and Partner, with the Covered Person and Partners home as the primary place of residence.
- the children must be within the age limits as stated in the Policy.
- the Covered Person and/or Partner must assume full parental responsibility and control, including any and all debts incurred by the child(ren) (i.e., charges for health care services and supplies)
- The Covered Person and/or Partner must be (1) a biological parent, or (ii) have a court appointed legal relationship with the child(ren) i.e. guardianship, adoption, foster child), or (iii) have been designated as the responsible party under a Qualified Medical Child Support Order (QMCSO).

*Dependency is determined in accordance with the applicable Internal Revenue Service guidelines.

B. In the case of a newborn infant of the Covered Person and/or Partner or enrolled dependent, such child shall be eligible for benefits for covered services from birth through age 31 days under the policy of their parents(s), subject to any applicable managed care or managed benefits provisions of this Policy. An infant age 32 days or over who meets the criteria IV, (1), (a) through (d) is eligible for benefits for covered services as a dependent child.

C. In the case of a full time student if the Covered Person and/or Partner, a full time student is eligible for coverage when he/she meets the criteria in IV, (1), (a) through (d) above; and is between the age limits as stated in the Policy and, is a full-time student at a recognized college, university, or trade school, is accredited by its corresponding trade of professional organization, or is approved by the State Department of Education or Public Health equivalent licensing department in other states.

D. In the case of an unmarried disabled dependent child of the Covered Person and/or Partner, where “disabled” means that the child is incapable of sustaining employment by reason of physical or mental handicap, the disabled child may continue as dependent beyond the age limit set forth in this Policy provided:

- proof of disability is submitted and accepted by Anthem BCBS. Note: Anthem BCBS may require proof of disability annually.
- the child became disabled prior to the age limit for a dependent child set forth in the Policy under which the child was eligible for benefits for Covered Services, and
- the child had comparable coverage as a dependent at the time of application for eligibility for benefits for Covered Services under this Policy.

Effective Date of Coverage

Coverage for Domestic Partners and eligible dependents of the Domestic Partner will be as follows:

A. Upon the firm's initial enrollment, provided all Domestic Partnership eligibility requirements are satisfied and approved by Anthem BCBS.

B. A newly hired Covered Person may enroll a Partner provided all Domestic Partnership eligibility requirements are satisfied and approved by Anthem BCBS. The Effective Date of coverage will be in accordance with any applicable waiting period in place by the PolicyHolder and/or Anthem BCBS.

C. In the case where the PolicyHolder has an open enrollment period, an existing Covered Person may enroll the Domestic Partner provided all Domestic Partnership eligibility requirements are satisfied and approved by Anthem BCBS. Eligibility for enrollment other than during the open enrollment period will be in compliance with Anthem BCBS Late Enrollee policy.

D. In the case where the PolicyHolder has no Open Enrollment Period, eligibility will be in compliance with Anthem BCBS Late Enrollee policy.

Termination

If the Domestic Partnership status changes such that the Partner is no longer eligible for coverage, the Covered Person must complete and file a Termination of Domestic Partnership form within 30 days of the change of such status.

Once a Termination of Domestic Partnership has been submitted, the Covered Person may not cover another partner for at least 12 months.

Continuation of Group Coverage

Domestic Partners may each continue coverage under applicable State or Federal extension of coverage laws. The termination of the Domestic Partner status shall be considered for the purpose of this rider as a qualifying event to allow for the application of such continuation of benefits.

Conversion to Individual Coverage

Upon termination of a Domestic Partnership, where the partner loses group health coverage, the Partner may apply for coverage through the Health Reinsurance Association (HRA).

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)

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (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)

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)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (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)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (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)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (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)

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)

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.