Anthem Blue Cross and Blue Shield
Blue View Basic Vision Care Member Certificate

Your vision care benefits are provided through a group insurance policy issued by Anthem Blue Cross and Blue Shield to go along with the health benefits provided by your employer's self-funded health plan. This member booklet fully explains your vision care benefits and how *you* can maximize them. Treat it as *you* treat the owner's manual for your car - store it in a convenient place and refer to it whenever *you* have questions about your vision care coverage.

Important phone numbers

Member Services

804-358-1551
in Richmond
800-451-1527
from outside Richmond

Coinsurance

The percentage of the allowable charge you pay for some covered services.

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How your vision care plan works

Your vision care

What is covered

To help care for your eyes, *your vision care plan* includes benefits for one routine eye examination per *covered person* per calendar year. In order to receive the highest level of benefits, *you* should seek care from a Blue View Vision participating *provider*.

Summary of benefits

This chart describes your covered services and payment responsibility for care received *in-network* and *out-of-network*. For *out-of-network* care, *you* will be responsible for the difference between the allowance and the *provider's* charge.

A list of services that are not covered begins on page 3.

	In-network		Out-of-network
	Copayment	Coinsurance	Payment allowance
Vision care one routine eye examination per calendar year	$15	0%	$30

What is not covered (Exclusions)

This list of services and supplies that are excluded from coverage by *your vision care plan* will not be covered in any case.

Your coverage does not include benefits for the following vision services:

- vision services or supplies unless needed due to eye surgery and accidental injury;
- routine vision care, except as outlined on page 2 of this booklet;
- experimental/investigative vision procedures or materials, as well as services related to or complications from such procedures;
- services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics;
- sunglasses or safety glasses and accompanying frames of any type;
- any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power;
- any lost or broken lenses or frames;
- any blended seg Td(materials,)Tj 51-438.55t;anyon

Timely filing of claims

Written notice of a claim is to be made within 20

Recovery of overpayment

Anthem shall have the right to recover any overpayment of

Changing your coverage

Who is eligible for coverage

You are eligible for vision care coverage if *you* are a participant in your employer's group health plan. Your eligible dependents covered under the group health plan are also eligible for vision care coverage. Forin

Important information about your vision care plan

Statement of ERISA rights

As a participant in this plan *you*

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

Assistance

If *you* have questions about your plan, contact your *Plan Administrator*. 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, listed in your telephone directory. *You* may also contact the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Employer premiums

Your employer is responsible for paying a monthly premium by the first day of the month for which coverage is purchased. *We* will allow employers a 31 day grace period to pay monthly premiums, except for the first month's premium. During this grace period, coverage will continue unless *we* receive a written notice of termination from your employer. *We* will notify your employer at least 15 days prior to terminating the group policy for non- payment of a monthly premium. *Anthem* is not responsible for costs *you* incur during any period (other than the grace period discussed above) when your employer fails to pay full premiums.

Changes in the vision care plan

We may amend this vision care plan by giving your employer at least 30 days written notice. Any amendment to the vision plan will change covered services to *covered persons* on the *effective date* of the change. Your employer and *Anthem* may mutually agree to amend or reduce benefits at any time.

Complaint and appeal process

In order for *your vision care plan* to remain responsive to your needs, we've established both a complaint process and an appeal process. Should *you* have a problem or question about *your vision care plan,* a Member Services representative will assist *you*. Most problems and questions can be handled in this manner. *You* may also file a written complaint or appeal with *us*. Complaints typically involve issues such as dissatisfaction about *your vision care plan's* services, quality of care, the choice of and accessibility to *your vision care plan's* providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by *your vision care plan*. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

Complaint Process

Upon receipt, your complaint will be reviewed and investigated. *You* will receive a response within 30 calendar days of *your vision care plan's* receipt of your complaint. If *we* are unable to resolve your complaint in 30 calendar days, *you* will be notified on or before calendar day 30 that more time is required to resolve your complaint. *We* will then respond to *you* within an additional 30 calendar days.

Important: Written complaints or any questions concerning *your vision care plan*

- the name of the vision care professional or facility that provided the service, including the date and description of the service provided and the charge.

Important: *You* may contact Member Services with your appeal or any questions concerning *your vision care plan* at the following:

Address:
Anthem Blue Cross and Blue Shield
Attention: Corporate Appeals Department
P.O. Box 27401
Richmond, VA 23279

Telephone:
804- 358- 1551
in Richmond
800- 451- 1527
from outside Richmond

You must file your appeal within either 15 months of the date of service or 180 days of the date *you* were notified of the *adverse benefit determination,* whichever is later.

How your vision care plan will handle your appeal

In reviewing your appeal, *we* will take into account all the information *you* submit, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing your appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by a practitioner who holds a non- restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

We will promptly acknowledge receipt of your appeal, and will resolve and respond to it as follows:

- For *pre- service claims, we* will respond in writing within 30 days after receipt of the request to appeal;
- For *post- service claims, we* will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals, *we* will respond orally within 1 working day after receipt, from the member or treating provider, of the request to appeal, and will then provide written confirmation of *our* decision to the member and treating provider within 24 hours thereafter. In no event will the notification be provided later than 72 hours after receipt of the request to appeal.

Web Page:
Information regarding The Office of the Managed Care Ombudsman may be found by accessing the State Corporation Commission's web page at:
http://www.scc.virginia.gov

The Virginia Department of Health Office of Licensure and Certification

If *you* have

Cancellation or termination

We can

amount of the *covered person's* claim for benefits. The damages shall not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. Under no circumstances shall this provision be construed to limit or preclude any extra

Definitions

Adverse benefit determination
is any denial, reduction of a benefit or failure to provide a benefit, in whole or in part, by the health plan.

Blue View Vision Network
is a network of eye care providers including optometrists, ophthalmologists, and opticians. To receive the highest level of benefits, you should seek care from a provider that participates in the Blue View Vision Network.

Coinsurance
is the percentage of the allowable charge you pay for some covered services.

Copayment
is the fixed dollar amount you pay for some covered services.

Covered persons
are you and enrolled eligible dependents.

Effective date
is the date coverage begins for you and/or your dependents enrolled under the vision care plan.

Group administrator
is the benefits administrator at your employer.

In-network
is care rendered by a Blue View Vision participating provider. In-network benefits are the highest level of benefits available under your vision care plan.

Out-of-network
is care that is not rendered by a Blue View Vision participating provider. Out-of-network care is covered at a lower level of benefits.

Plan administrator
is your group administrator.

Post-service claims

are all claims other than pre-service claims. Post-service claims include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where you request

Pre-service claims

are claims for a service where the terms of the health plan require the member to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If you call to receive authorization for a service when authorization in advance is not required, that claim will be considered a post-service claim.

Providers

are licensed eye care professionals including ophthalmologists, optometrists, and opticians.

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End of Certificate

Vision discount program

To help *you* care for your eyes, valuable vision discounts are available to *you* in addition to the routine vision benefits defined in the What is covered section of this booklet. In order to take advantage of the available discounts, *you* should seek care from a Blue View Vision participating provider.

Your Eyewear Discounts

When *you* visit a Blue View Vision participating eye care professional or vision center, you'll pay the discount price for as many pairs of eyeglasses and/or supplies of conventional

Anthem Blue Cross and Blue Shield
2015 Staples Mill Road
Post Office Box 27401
Richmond, VA 23279

Anthem