Vision Certificate of Coverage

(herein called the "Certificate")

Blue View Vision

ADMINISTERED BY

Blue Cross and Blue Shield of Georgia, Inc.

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

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Customer Service at the number on the back of your Identification Card.

Effective 01/01/2015

Introduction

Welcome to BCBSGA!

This Benefit Booklet has been prepared by BCBSGA (the Administrator), on behalf of your Employer, to help explain your vision care benefits. Please refer to this Benefit Booklet whenever you require vision services. It describes how to access vision care, what vision services are covered by the Plan, and what portion of the vision costs you will be required to pay.

The coverage described in this Benefit Booklet is based on the conditions of the Administrative Services Agreement issued to your Employer, and is based on the benefit plan that your Employer chose for you. The Administrative Services Agreement, Benefit Booklet, and any amendments or riders attached to the same, form the terms under which Covered Services and supplies are available.

This Benefit Booklet should be read in its entirety. Since many of the provisions are interrelated, you should read the entire Benefit Booklet to get a full understanding of your coverage.

Many words used in the Benefit Booklet have special meanings. These words appear in capitals and are defined for you. Refer to these definitions in the **"Definitions"** section for the best understanding of what is being stated.

Read your Benefit Booklet carefully. The Benefit Booklet sets forth many of the rights and obligations between you and the Plan. Payment of benefits is subject to the provisions, limitations, and exclusions of your Benefit Booklet. It is therefore important that you read your Benefit Booklet.

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SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the amount of benefits available when you receive Covered Services from a Provider. Please refer to the **Covered Services** section 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 Certificate including any attachments or riders.

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

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network Providers	**Non-Network Providers**
Eye Exam Limited to one exam per Member every Calendar Year.	$10 Copayment	Reimbursed up to $30
Prescription Lenses Limited to one set of lenses per Member every Calendar Year.		

• **Basic Lenses (Pair)**
  • Single Vision lenses
  • Bifocal lenses
  • Trifocal lenses
 	
  Includes:
  • Factory scratch coating
  • Polycarbonate and Photochromic lenses (for children under age 19)
	$10 Copayment	Reimbursed up to $25
		Reimbursed up to $40
		Reimbursed up to $55

Frames Limited to one set of frames per Member every other Calendar Year.	No Copayment Allowable Amount up to $150 retail allowance	Reimbursed up to $45

COVERED SERVICES	COPAYMENTS/MAXIMUMS	
	Network Providers	**Non-Network Providers**
Prescription Contact Lenses (traditional or disposable)	No Copayment	
Non-Elective Contact Lenses (Availability once every Calendar Year.)	Covered in full	Reimbursed up to $210
• **Elective Contact Lenses** (Availability once every Calendar Year.)	No Copayment $130 plan allowance	Reimbursed up to $105

Note: If you chose covered Non-Elective Contact Lenses or Elective Contact Lenses, no benefits will be available for covered eyeglass lenses in that period.

VISION CARE SERVICES / ADDITIONAL SAVINGS	MEMBER COST / DISCOUNT	
	Network Providers	**Non-Network Providers**
Lens Options / Upgrades		
• UV Coating	**Member Cost:** $15	Discounts on lens upgrades are not available Out-of-Network
• Tint (solid and Gradient)	$15	
• Standard Polycarbonate	$40	
• Transitions lenses	$75	
• Other Photochromics	$75	
• Progressive Lenses		
○ Standard	$65	
○ Premium Tier 1	$91	
○ Premium Tier 2	$97	
○ Premium Tier 3	$103	
• Standard Anti-Reflective Coating	$45	
• Premium Tier 1 Anti-Reflective Coating	$57	
• Premium Tier 2 Anti-Reflective Coating	$68	
• Other Add-ons and Services	20% off retail price	
Additional Savings*	**Member Savings:**	
• Additional Pair of complete Eyeglasses	40% discount off retail	Discounts are not available Out-of-Network
• Contact Lenses – Conventional Discount applied to materials only	15% off retail price	
• Eyewear Accessories Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases.	20% off retail price	

*****The Plan's additional savings program is subject to change without notice.

Laser Vision Correction Surgery
Pay a discounted amount per eye for LASIK Vision correction. For more information, to go Special Offers at www.bcbsga.com and select vision care.

Please Note: Savings on additional eyewear and accessories are available after you use your initial frame or contact lens allowance.

DEFINITIONS

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

Actively at Work - Present and capable of carrying out the normal assigned job duties of the Group. Subscribers who are absent from work due to a health related disability, maternity leave or regularly scheduled vacation will be considered Actively at Work.

Benefit Booklet – This summary of the terms of your vision benefits
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Coinsurance - A percentage of the Maximum Allowable Amount for which you are responsible to pay. Your Coinsurance will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment – A specific dollar amount indicated in the Schedule of Benefits for which you are responsible.

Covered Services - Services and supplies or treatment as described in the Certificate which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service~~s~~, supply or treatment must be:

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

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

Dependent - A Subscriber's spouse and dependent children who have met Our eligibility requirements and have not reached the age limit shown in the Eligibility and Enrollment Section of this Certificate.

Effective Date - The date when your coverage begins under this Certificate. A Dependent's coverage begins on the Effective Date of the sponsoring Subscriber.

Elective Contact Lenses - All prescription contact lenses that are cosmetic in nature or are not Non-Elective Contact Lenses.

Eligible Person - A person who satisfies the Group's eligibility requirements and is entitled to apply to be an Employee.

Enrollment Date - The first day of coverage or, if there is a waiting period, the first day of the waiting period (typically the date employment begins).

Family Coverage - Coverage for the Subscriber and eligible Dependents.

Identification Card - A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Late Enrollee – An Eligible Person whose enrollment did not occur on the earliest date that coverage can become effective under this Certificate, and who did not qualify for Special Enrollment.

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

Member Reimbursement Amount - The maximum amount allowed for Covered Services as listed in the Schedule of Benefits. The amount is subject to any Deductible, limitations or Exclusions listed in this Certificate.

Member - A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called “you” and “your.”

Network Provider – A provider who has entered into a contractual agreement Us to provide Covered Services and certain administration functions for the network associated with this Certificate.

Non-Elective Contact Lenses - Contact lenses which are provided for reasons that are not cosmetic in nature. Non-Elective Contact Lenses are Covered Services when the following conditions have been identified or diagnosed:

- Keratoconus: a condition where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses and the Vision Care Provider attests to visual improvement. .
- High Ametropia exceeding -10 D or +10 D in spherical equivalent in either eye.
- Anisometropia of 3 D or more in spherical equivalent.
- Patients whose vision can be corrected two (2) lines of improvement on the visual acuity chart with contact lenses as compared to best corrected visual acuity with standard spectacle lenses.

Non-Network Provider – A Provider who has not entered into a contractual agreement with Us for the network associated with this Certificate.

Open Enrollment – A period of enrollment designated by the Plan in which Eligible Persons or their Dependents can enroll without penalty after the initial enrollment; see the Eligibility and Enrollment section for more information.

Plan (or We, Us, Our) – The group vision benefit plan provided by the Employer and described in this Benefit Booklet.

Premium - The periodic charges that the Participant or the Plan must pay the Claims Administrator to maintain coverage.

ELIGIBILITY AND ENROLLMENT

You have coverage provided under this Certificate because of your employment with/membership with/retirement from the Group. You must satisfy certain requirements to participate in the Group's benefit plan. These requirements may include probationary or waiting periods and Actively at Work standards as determined by the Group or state and/or federal law and approved by Us.

Your Eligibility requirements are described in general terms below. For more specific eligibility information, see your Human Resources or Benefits Department.

Eligibility

The following eligibility rules apply unless you are notified by Us and the Group.

Subscriber

To be eligible to enroll as a Subscriber, an individual must:

- Be either: An employee, Member, or retiree of the Group, and:
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and be Actively At Work;
- Meet the eligibility criteria stated in the Group Contract.

Dependents

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

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

Your Eligible Dependents Include:

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

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

To obtain coverage for children, We may require that the Subscriber complete a "Dependency Affidavit" and provide Us with a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under this Certificate.

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

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

Please Note: For the purpose of this Contract, a spouse is the Subscriber's legal spouse as recognized by the state in which you live.

Enrollment

Initial Enrollment

An Eligible Person can enroll for Single or Family Coverage by submitting an application to the Plan. The application must be received by the date stated on the Group Contract or the Plan's underwriting rules for initial application for enrollment. If We do not receive the initial application by this date, the Eligible Person can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, which ever is applicable.

If a person qualifies as a Dependent but does not enroll when the Eligible Person first applies for enrollment, the Dependent can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, which ever is applicable.

It is important for you to know which family members are eligible to apply for benefits under Family Coverage. See the section on Eligible Dependents.

Newborn and Adopted Children

A newborn or an adopted child is covered automatically fro 31 days from the moment of birth or date of assumption of legal responsibility up to age 26. If additional Premium is required to continue coverage beyond the 31-day period, the Member must notify BCBSGA of the birth or adoption and pay the required Premium within the 31-day period or coverage will terminate.

Types of coverage requiring additional Premium include One-Person Coverage and Two-Person Coverage. If a Member has Family Coverage or Multi-Person Coverage, no additional Premium is required and coverage automatically continues. However, the Member should notify BCBSGA of the birth or adoption within 31 days to ensure accurate records and timely payment of claims.

Extending coverage for a newborn child or an adopted child being added to One-Person or Two-Person Coverage beyond the 31-day period requires late enrollment. Please refer to the **"Late Enrollees"** provision in this section.

Foster Children

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

Foster children for whom a Member assumes legal responsibility are not covered automatically. In order for a foster child to have coverage, a Member must provide confirmation of a valid foster

parent relationship to BCBSGA. Such confirmation must be furnished at the Member's expense. When the application is processed, the Effective Date will be the first of the month following your Group's employee waiting period.

Any child under the age of 18 who is adopted by a Member, including a child placed with a Member for adoption will be eligible for coverage upon the date of placement with the Member. A child will be considered placed for adoption when a Member becomes legally obligated to support that child, totally or partially, prior to that child's adoption. If a child placed for adoption is not adopted, all coverage ceases when the placement ends, and will not be continued.

Adding a Child due to Award of Legal Custody or Guardianship

If a Subscriber or the Subscriber's spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage would start on the date the court granted legal custody or guardianship. If We do not receive an application within the 31-day period, the child will be treated as a Late Enrollee.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child under this Certificate, We will permit your child to enroll at any time without regard to any Open Enrollment limits and shall provide the benefits of this Certificate in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under this Certificate will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Special Enrollment/Special Enrollees

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other vision insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Certificate, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Plan, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If We receive an application to add your Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, that person is only eligible for coverage as a Late Enrollee. Application forms are available from the Plan.

Medicaid and CHIP Special Enrollment/Special Enrollees

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Late Enrollees

You are considered a Late Enrollee if you are an Eligible Person or Dependent who did not request enrollment for coverage:

- During the initial enrollment period; or
- During a Special Enrollment period; or
- As a newly eligible Dependent who failed to qualify during the Special Enrollment period and did not enroll within 31 days of the date you were first entitled to enroll.

You may apply for coverage at any time during the year as a Late Enrollee. However, you will not be enrolled for coverage with the Plan until the next Open Enrollment Period.

Open Enrollment Period

An Eligible Person or Dependent who did not request enrollment for coverage during the initial enrollment period, or during a Special Enrollment period, may apply for coverage at any time, however, will not be enrolled until the Group's next annual enrollment.

Open Enrollment means a period of time (at least 31 days prior the Group's renewal date and 31 days following) which is held no less frequently than once in any 12 consecutive months.

Notice of Changes

The Subscriber is responsible to notify the Group of any changes which will affect his or her eligibility or that of Dependents for services or benefits under this Certificate. The Plan must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another vision plan. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of payments from the Group for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 31days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications by the Group must be in writing and on approved forms. Such notifications must include all information reasonably required to effect the necessary changes.

A Member's coverage terminates on the last day of the billing period in which the Member ceases to be in a class of Members eligible for coverage. The Plan has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's coverage.

Effective Date of Coverage

If you apply when first eligible, your coverage will be effective on the date your Group's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision your Group requires.

If an employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the employee returns to active status. If an employee is not actively at work due to health status, this provision will not apply. An employee is also a person still employed by the Group but not currently active due to health status.

For information on your specific Effective Date of Coverage under this Certificate, please see your human resources or benefits department. You can also contact Us by calling the number located on the back of your Identification (ID) Card or by visiting www.bcbsga.com.

Statements and Forms

Subscribers (or applicants for membership) must complete and submit applications or other forms or statements the Plan may reasonably request.

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

Delivery of Documents

We will provide an Identification Card for each Member and a Certificate for each Subscriber.

TERMINATION AND CONTINUATION

Termination of Coverage (Group)

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

- The Group fails to pay premiums in accordance with the terms of the Vision Master Contract.
- The Group performs an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage.
- The Group has fallen below our minimum employer contribution or group participation rules. We will submit a written notice to the Group and provide the Group 60 days to comply with these rules.
- We terminate, cancel or non-renew all coverage under a particular policy form, provided that:
- We provide at least 180 days notice of the termination of the policy form to all Members;
- We offer the Group all other small group (employer) or large group (employer) policies, depending on the size of the Group, currently being offered or renewed by us for which you are otherwise eligible; and
- We act uniformly without regard to the claims experience or any health status related factor of the individuals insured or eligible to be insured.

Termination of Coverage (Individual)

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

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

If you engage in fraudulent conduct or furnish Us fraudulent or misleading material information relating to claims or application for coverage, then We may terminate your coverage. Termination is generally effective 31 days after Our notice of termination is mailed, except when indicated otherwise in the Schedule of Benefits. We will also terminate your Dependent's coverage, generally effective on the date your coverage is terminated. We will notify the Group in the event We terminate you and your Dependent's coverage.

If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice to the Group. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for services received through such misuse.

Removal of Members

Upon written request through the Group, a Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Reinstatement

You will not be reinstated automatically if coverage is terminated. Re-application is necessary, unless termination resulted from inadvertent clerical error. No additions or terminations of membership will be processed during the time your or the Group's request for reinstatement is being considered by Us. Your coverage shall not be adversely affected due to the Group's clerical error. However, the Group is liable to Us if We incur financial loss as a result of the Group's clerical error.

Continuation of Coverage (Georgia Law)

Any employee insured in Georgia under a company welfare benefit plan whose employment is terminated other than for cause, may be entitled to certain continuation benefits. If you have been continuously enrolled for at least six months under this Certificate, or this and its immediately preceding health insurance contract, you may elect to continue Group health coverage for yourself and your enrolled family members for the rest of the month of termination and three additional months by paying the appropriate Premium.

This benefit entitles each member of your family who is enrolled in the company's employee welfare benefit plan to elect continuation independently.

Cost

These continuation benefits are available without proof of insurability at the same Premium rate charged for similarly insured employees. To elect this benefit you must notify the company's Group health benefit Plan Administrator within 30 days of the date your coverage would otherwise cease that you wish to continue your coverage and you must pay the required monthly Premiums in advance.

This continuation benefit is not available if:

- Your employment is terminated for cause; or
- Your health plan enrollment was terminated for your failure to pay a Premium or Premium contribution; or
- Your health plan enrollment is terminated and replaced without interruption by another group contract; or
- Health insurance is terminated for the entire class of employees to which you belong; or
- The Group terminates health insurance for all employees.

Termination of Benefits

Continuation coverage terminates if you do not pay the required Premium on time or you enroll for other group insurance or Medicare.

Federal Continuation of Coverage (COBRA)

The following applies if you are covered under a Group which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

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

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of vision coverage under the Group's vision plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Group's vision plan is lost because of the qualifying event. Under the Group's vision plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Group for Premium payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group's vision plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group's vision plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Group's vision plan because any of the following qualifying events happens:

- The parent-Subscriber dies;
- The parent-Subscriber's hours of employment are reduced;
- The parent-Subscriber's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Group's vision plan as a "dependent child."

If Your Group Offers Retirement Coverage

Sometimes, 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 the Group, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Group's vision plan, the retired Subscriber will become a qualified beneficiary with respect to the bankruptcy. The retired Subscriber's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under Group's vision plan.

When is COBRA Coverage Available

COBRA continuation coverage will be offered to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), then you must notify the Group of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided

Once the Group receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage.

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

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Group's vision plan is determined by the Social Security Administration to be disabled and you notify the Group in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

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

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

If You Have Questions

Questions concerning your Group's vision plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage (Age 60 and Over)

A Subscriber (and eligible Dependents), insured in Georgia under a company welfare benefit plan, who has exhausted the continuation benefits listed above, is eligible for additional continuation rights if that Subscriber was age 60 or older and covered for continuation benefits under the regular continuation provision.

There are certain requirements, which must be met:

- you must have been covered under a group plan which covers 20 or more employees; and
- you must have been continuously enrolled for at least six months under this Contract.

This continuation benefit is not available if:

- your employment is terminated voluntarily for other than health reasons;
- the vision plan enrollment was terminated because you failed to pay a Premium or Premium contribution;
- the vision plan enrollment is terminated and replaced without interruption by another group contract;
- vision insurance is terminated for the entire class of employees to which you belong;
- the company terminated vision insurance for all employees;
- your employment was terminated due to reasons which would cause a forfeiture of unemployment compensation (Chapter 8 of Title 34 “Employment Security Law”).

The following eligibility requirements apply:

- you must have been 60 years of age or older on the date coverage began under the continuation provision;
- your Dependents are eligible for coverage if you meet the above requirements;
- your spouse and any Covered Dependent children whose coverage would otherwise terminate because of divorce, legal separation, or your death may continue if the surviving spouse is 60 years of age or older at the time of divorce, legal separation or death.

The monthly charge (Premium) for this continuation coverage will not be greater than 120% of the amount you would be charged as a normal Group Member. You must pay the first Premium for this continuation of coverage under this provision on the regular due date following the expiration of the period of coverage provided under COBRA or state continuation.

Your continuation rights terminate on the earliest of the following:

- the date you fail to pay any required Premium when due;
- the date the Vision Master Contract is terminated; (If the Vision Master Contract is replaced, coverage will continue under the new group plan.);
- the date you become insured under any other group vision plan; or
- the date you or your divorced or surviving spouse becomes eligible for Medicare.

Extension of Benefits in Case of Total Disability

If the Vision Master Contract is terminated for non-payment of subscription charges, or if the Group terminates the Contract for any reason; or if the Contract is terminated by BCBSGA (with 60 days written notice), then in such event the coverage of a totally disabled Subscriber will be as follows:

Contract benefits for the care and treatment of the specific illness, disease or condition that caused the total disability will be extended up to twelve (12) months from the date of termination of the Group Contract or to the maximum of the amount payable under this Contract during the extension period.

NOTE: BCBSGA considers total disability a condition resulting from disease or injury where:

- the Member is not able to perform the major duties of his or her occupation and is not able to work for wages or profit; or
- the Member’s Dependent is not able to engage in most of the normal activities of a person of the same age and sex.

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 health coverage for yourself and your Dependents (if any) under this Certificate in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Military service” means 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 eligible Dependents (if any) under this Certificate by notifying your employer in advance and payment of any required contribution for health 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 Member contribution, if any, for continuation of health coverage.

If continuation is elected under this provision, the maximum period of health coverage under this Certificate shall be the lesser of:

1. The 18-month period (24 months if continuation is elected on or after 12/10/2004) beginning on the first date of your absence from work; or
2. The day after the date on which You fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under this Certificate. No exclusions or waiting period may be imposed on you or your eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Family and Medical Leave Act of 1993

A Subscriber who is taking a period of leave under the Family and Medical Leave Act of 1993 (the Act) will retain eligibility for coverage during this period. The Subscriber and his or her Dependents shall not be considered ineligible due to the Subscriber not being Actively at Work.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without medical underwriting and without imposition of an additional waiting period for Pre-Existing Conditions. To obtain coverage for a Subscriber upon return from leave under the Act, the Group must provide the Plan with evidence satisfactory to Us of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

HOW TO OBTAIN COVERED SERVICES

Services and Benefits

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

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Certificate does not give anyone any claim, right, or cause of action against the Plan based on what a Provider of vision care, services or supplies, does or does not do.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Provider or in any Provider's facilities.

COVERED SERVICES

This section describes the Covered Services available under your vision care benefits. All Covered Services are subject to the exclusions listed in the Exclusions section and all other conditions and limitations of the Certificate. The amount payable for Covered Services varies depending on the type of services and whether or not you choose optional services and/or custom materials rather than standard services and supplies. Payment amounts are specified in the Schedule of Benefits.

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

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

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

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

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

Benefits include factory scratch coating. All other coating, other lens materials and treatments are not covered benefits. You will be responsible for amounts in excess of the benefit maximum. Photochromic and polycarbonate lenses prescribed for a child under age 19 are covered in full.

Elective Contact Lenses. You have an allowance per Benefit Period toward elective cosmetic contact lenses selected in lieu of the eyeglass lens benefit. If you choose contact lenses greater than the allowance, you are responsible for the difference. If you choose to receive contact lenses, no benefits will be paid for lenses during that same Benefit Period.

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

1. Extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses; or
2. Keratoconus - unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; or

3. High Ametropia - unusually high levels of near sightedness, far sightedness, or
4. Anisometropia - when one eye requires a much different prescription than the other eye.

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

Fitting Fees

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

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

Cosmetic Option

Benefits are available for the services below in accordance with the Additional Savings Program. The Member will be responsible for the following items at a discounted rate when provided by a Network Provider:

- Blended lenses
- Contact lenses (except as noted herein)
- Oversize lenses
- Progressive multifocal lenses
- Photochromatic lenses, or tinted lenses
- Coated lenses
- Frames that exceed the Maximum Allowable Amount
- Cosmetic Spectacle Lenses
- Ultra-violet coating
- Scratch resistant coating
- Polycarbonate lenses
- Anti-reflective coating
- Optional cosmetic items

EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items that may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or supplies are Covered Services.

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

1. Received from an individual or entity that is not a Provider, as defined in this Certificate.
2. For any condition, disease, defect, aliment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
3. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
4. For illness or injury that occurs as a result of any act of war, declared or undeclared.
5. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
6. For which you have no legal obligation to pay in the absence of this or like coverage.
7. Received from an optical or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
8. Prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
9. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
10. For missed or canceled appointments.
11. In excess of Member Reimbursement Amount.
12. Incurred prior to your Effective Date.
13. Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.
14. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
15. For sunglasses and accompanying frames.
16. For safety glasses and accompanying frames.
17. For inpatient or outpatient hospital vision care.
18. For Orthoptics or vision training and any associated supplemental testing.
19. For non-prescription lenses.
20. For two pairs of glasses in lieu of bifocals.
21. For Plano lenses (lenses that have no refractive power).
22. For medical or surgical treatment of the eyes.

23. Lost or broken lenses or frames, unless the Member has reached his or her normal interval for service when seeking replacements.
24. For services or supplies not specifically listed in the Certificate.
25. Certain brands on which the manufacturer imposes a no discount policy.
26. For services or supplies combined with any other offer, coupon or in-store advertisement.
27. For the following:
    - For Cosmetic Spectacle Lenses
    - For optional cosmetic items.

CLAIMS PAYMENT

How to File a Claim

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

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

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

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

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

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

Please send claims and itemized bills to the following address:

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

Assignment

This Certificate is not assignable by the Group without the written consent of the Plan. The coverage and any benefits under this Certificate are not assignable by any Member without the written consent of the Plan, except as described in this Certificate.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate will be responsible for any charge for services.

Explanation of Benefits

After you receive vision care, you will often receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by your coverage;
- the amount for which you are responsible (if any);
- general information about your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.

GENERAL PROVISIONS

Entire Contract

Note: The law of the state in which the Group Contract was issued will apply unless otherwise stated herein.

This Certificate, the Group Contract, the Group application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire Contract between the Plan and the Group and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Group and any and all statements made to the Group by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

Form or Content of Certificate

No agent or employee of the Plan is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by an officer of the Plan.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Plan, disability of a significant part of a Provider's personnel or similar causes, or the rendering of vision care services provided under this Certificate is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Providers shall render services provided under this Certificate insofar as practical, and according to their best judgment; but the Plan and Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Coordination of Benefits

We consider this Plan primary in all circumstances.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under this Certificate shall not duplicate any benefits to which Members are entitled or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or Vendor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise

recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Relationship of Parties (Group-Member-Plan)

Neither the Group nor any Member is the agent or representative of the Plan.

The Group is fiduciary agent of the Member. The Plan's notice to the Group will constitute effective notice to the Member. It is the Group's duty to notify the Plan of eligibility data in a timely manner. The Plan is not responsible for payment of Covered Services of Members if the Group fails to provide the Plan with timely notification of Member enrollments or termination's.

Conformity with Law

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

Modifications

This Certificate allows the Group to make the Plan coverage available to eligible Members. However, this Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Group Contract, or by mutual agreement between the Plan and the Group without the permission or involvement of any Member. Changes will not be effective until 30 days after We provide written notice to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting the Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Certificate.

Clerical Error

Clerical error, whether of the Group or the Plan, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Complaint and Appeals Procedures before filing a lawsuit or other legal action of any kind against Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has able to disregard any conditions or restrictions contained in this Certificate, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, in its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The following provision only applies where the interpretation of this Certificate is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

The Plan, or anyone acting on Our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, We, or anyone acting on Our behalf, has complete discretion to determine the administration of Your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are covered. However, a Member may utilize all applicable Grievance and Appeals Procedures.

The Plan, or anyone acting on Our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of the Certificate. This includes, without limitation, the power to construe the Group Contract, to determine all questions arising under the Certificate, to resolve Member Grievances and Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Group Contract the Certificate, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

COMPLAINT AND APPEALS PROCEDURES

Our customer service representatives are specially trained to answer your questions about Our vision benefit plans. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Reimbursement amounts;
- Specific claims or services you have received;

You will be notified, in writing, if a claim or other request for benefits is denied in whole or in part. If such a request is denied, the notice of denial will explain why benefits were denied and describe your rights under the Appeals Procedure. A Complaint Procedure also exists to help you understand the Plan's determinations.

The Complaint Procedure

A Complaint Procedure is available to provide reasonable, informative responses to complaints that you may have concerning the Plan. A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Plan of its procedures and contracts. The Plan invites you to share any concerns that you may have over benefit determinations or coverage cancellations

If you have a complaint or problem concerning benefits or services, please contact Us. You may submit your complaint by letter or by telephone call. Or, if you wish, you may meet with your local service representative to discuss your complaint.

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

The Appeals Procedure

An appeal is a formal request from you for the Plan to change a previous determination. If you are notified in writing of a Coverage Denial or any other adverse decision by Us, you will be advised of your right to an internal appeal.

A Coverage Denial means Our determination that a service, treatment, drug or device is specifically limited or excluded under this Certificate.

The internal appeals process may be initiated by the Member, the Member's authorized representative, or a Provider acting on behalf of the Member within 60 days of receipt of Our written notice of a Coverage Denial, or any other adverse decision made by Us, but must be filed within six months of your receipt of the initial decision. The request should include any medical information pertinent to the appeal. All portions of the medical records that are relevant to the appeal and any other comments, documents, records or other information submitted by the Member relating to the issue being appealed, regardless of whether such information was considered in making the initial decision, will be considered in the review of the appeal. Any new medical information pertinent to the appeal will also be considered. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal.

If a representative is seeking an appeal on behalf of a Member, We must obtain a signed Designation of Representation (DOR) form from the Member. The appeal process will not begin until BCBSGA has received the properly completed DOR. We will forward a Designation of Representation form to the Member for completion.

The individuals responsible for reviewing your request for an internal appeal will not be the same individuals who made the initial denial or determination. They will not be the subordinates of the initial decision-maker either and no deference will be given to the initial decision.

Within a reasonable period of time but no later than 30 days after receiving a written or an oral request for an appeal, We will send a written decision to the Member or their authorized representative.

Contact Person for Appeals

The request for an internal appeal must be submitted to the following address or telephone number or to the appeal address or telephone number provided on your written notice of an adverse decision:

Blue View Vision
ATTN: Appeals
555 Middle Creek Parkway
Colorado Springs, CO 80921

Telephone Number: 866-723-0515

The person holding the position named above will be responsible for processing your request.

The Plan encourages its Members to submit requests for appeal in writing. The request for appeal should describe the problem in detail. Attach copies of bills, medical records, or other appropriate documentation to support the appeal that may be in your possession.

You must file appeals on a timely basis. As state above, you are encouraged to file internal appeals within 60 days of your receipt of the Plan's initial decision. Internal appeals must be filed, however, within six months of your receipt of the initial decision.

Vision Services

We are not liable for the furnishing of Covered Services, but merely for the payment of them. You shall have no claim against Us for acts or omissions of any Provider from whom you receive Covered Services. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure before filing a lawsuit or other legal action of any kind against the Plan. If your vision benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

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