Anthem

Virginia United Methodist Conference Clergy Managed Care Plan

Vision Plan

Take Control of Your Health

Your Anthem Plan

anthem.com

01/01/2016

Anthem Blue Cross and Blue Shield (trade name of Anthem Health Plans of Virginia, Inc.) Blue View 130 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
800-582-6941

How to obtain language assistance

Anthem is committed to communicating with *our* members about their health plan, regardless of their language. *Anthem* employs a Language Line interpretation service for use by all of *our* Member Services Call Centers. Simply call the Member Services phone number on the back of your ID card and a representative will be able to assist *you*. Translation of written materials about your benefits can also be requested by contacting Member Services. In the event of a dispute, the provisions of the English version will control.

Note: 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 the customer service number.)

Hours of Operation:

Monday-Friday
8:00 a.m. to 6:00 p.m. ET
Saturday
9:00 a.m. to 1:00 p.m. ET

Visit us on-line at:

www.anthem.com

Key words

There are a few key words *you* will see repeated throughout this booklet. *We've* highlighted them here to make the booklet easier to understand. In addition, *we* have included a **Definitions** section that lists the various words referenced. A defined word will be italicized each time it is used.

We, us, our, Anthem

Anthem Blue Cross and Blue Shield.

Covered persons
You and enrolled eligible dependents.
You
The enrolled employee.
Your vision care plan
Anthem vision care plan.
Copayment
The fixed dollar amount you pay for some covered services.

Table of contents

page

How your vision care plan works **1**

Choose a vision care provider 1

Out-of-network care 1

What is covered **2**

Summary of benefits 2

What is not covered (Exclusions) **4**

Claims and payments **5**

How Anthem pays a claim 5

When you must file a claim 5

Changing your coverage **8**

Who is eligible for coverage 8

Ending coverage 8

Important information about your vision care plan **9**

Grievance and appeal process 10

Definitions **17**

Index **19**

Vision discount program **20**

How your vision care plan works

Your vision care plan provides vision care services within a special network of vision care *providers*. *You* will receive benefits based on where *you* receive vision care services and the limits stated in the **Summary of benefits** and related exclusions. This section of your vision care booklet details how to access and make the most of your vision care benefits.

Carry your ID card

Your Anthem Blue Cross and Blue Shield ID card identifies *you* as a member. When *you* show your ID card to your vision care *providers,* they will file your claims for *you* in most cases. Carrying your card at all times will ensure *you* always have this member information with *you* when *you* need it.

Choose a vision care provider

To receive *in-network* benefits, *you* should receive care from a licensed optometrist, ophthalmologist, or optician that participates in the Blue View Vision Network. Refer to your participating *provider* listing to choose a vision care *provider* with a location that is convenient for *you*.

Many participating *providers* offer complete vision care services while others may offer only partial services such as dispensing eyeglasses or contact lenses. Follow the key in your *provider* listing to see which services each *provider* offers.

How to find a vision care provider in the network

There are four ways *you* can find out if a vision care *provider* participates in the Blue View Vision Network:

- Refer to *your vision care plan's* directory of network *providers* at www.anthem.com, which lists vision care *providers* that participate in the Blue View Vision Network.
- Call *Anthem's* Member Services.
- Check with your vision care *provider*.
- Ask your group administrator.

Out-of-network care

Out-of-network care is vision care services received from a *provider* who does not participate in the Blue View Vision Network. *Out-of-network* care is covered at a lower level of benefits than *in-network* care. When you seek care from a licensed optometrist, ophthalmologist, or optician, you will receive a set dollar allowance for covered services as stated in the **Summary of benefits**.

What is covered

To help care for your eyes, *your vision care plan* includes coverage for routine vision services. 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 can be found in the **What is not covered** section.

The following vision services are available per covered person. Your *in-network* and *out-of-network* allowances for eyewear cannot be combined. Covered benefits may not be used in conjunction with any coupons, special offers, two-for-one offers or other *provider* promotions.

	In-network		Out-of-network
	Copayment	**Plan allowance (if any)**	**Reimbursement**
Vision care			
Routine eye examination one routine eye examination per calendar year	$15	*	$30
Standard contact lens fit and follow-up one per calendar year	$0	*	$35
A premium contact lens fit and follow-up is also available for a discount off of the retail price. In addition, there is a $55 allowance in-network and a $35 reimbursement for out-of-network.			
The standard contact lens fitting and two follow-up visits are available once a comprehensive eye exam has been completed. A standard contact lens fitting includes spherical, clear contact lenses for conventional wear and planned replacement (examples include but are not limited to disposables, frequent replacement lenses, etc.). A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric lenses, multifocal lenses, etc.). Within a calendar year, *you* may receive a benefit for either a standard or premium contact lens fitting, but not both.			
Lenses one pair of standard lenses per calendar year with an additional $65 fee for standard progressive lenses			
Single	$0	*	$25
Bifocal	$0	*	$40
Trifocal	$0	*	$55
Your vision care *provider* will order the proper lenses necessary to correct your vision and verify the accuracy of the finished lenses. Covered lenses include standard plastic (CR39) and the following types of lenses: single lenses; bifocal lenses; trifocal lenses (FT25-28); factory scratch coating; an allowance toward standard progressive lenses;			

polycarbonate lenses (covered for dependent children under the age of 19); and photochromic lenses (covered for dependent children under the age of 19).

Frames**	$0	*	$45

$130 retail allowance toward any frames purchased in-network every two years

Your vision care *provider* will assist *you* in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to maintain comfort and efficiency. If *you* go to a participating vision care *provider* and choose frames that exceed the benefit allowance shown on the **Summary of benefits**, *you* will be responsible for the difference in cost.

*For *in-network* services, *you* will only be responsible for the *copayments* listed.

**Members through age 18 are not eligible for the benefit allowance and must use the *Anthem* formulary, which is a selection of frames that are available from Blue View Vision Network *providers* at no *copayment*.

Elective contact lenses**	$0	*	$105

$130 allowance toward contact lenses instead of eyeglasses per calendar year

If *you* choose contact lenses, no benefits are available for lenses and frames. Should *you* choose contact lenses that exceed the benefit allowance shown on the **Summary of benefits**, *you* will be responsible for the difference in cost.

*For *in-network* services, *you* will only be responsible for the *copayments* listed.

**Members through age 18 are not eligible for the benefit allowance and must use the *Anthem* formulary, which is a selection of contact lenses that are available from Blue View Vision Network *providers* at no *copayment*.

Non-elective contact lenses**	$0	*	$210

instead of eyeglasses per calendar year

Non-elective contact lenses, provided for reasons that are not cosmetic in nature, are covered when one of the following conditions has been identified or diagnosed: extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses; keratoconus, an unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; high ametropia, unusually high levels of nearsightedness or farsightedness; or anisometropia, when one eye requires a much different prescription than the other eye.

*For *in-network* services, *you* will only be responsible for the *copayments* listed.

**Members through age 18 must use the Anthem formulary, which is a selection of contact lenses that are available from Blue View Vision Network providers at no copayment.

In order to receive the total contact lens allowance (elective or non-elective), the benefit must be completely used at the time of initial service, and no amount of the allowance may be carried forward to subsequent materials in the same or the following calendar year.

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 in the **What is covered** section 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;
- cosmetic lens options that are not specifically listed in the **Summary of benefits**;
- any frame in which the manufacturer has imposed a no discount policy;
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity;
- any other vision services not specifically listed as covered; or
- for members through age 18, no benefit for frames or contact lenses purchased outside of the *Anthem* formulary.

Your coverage also does not include benefits for services or supplies if they are:

- not listed as covered under *your health plan*;
- received before the *effective date* or after a covered person's coverage ends;
- given by a member of the covered person's immediate family;
- provided under federal, state, or local laws and regulations. This includes Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not you waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. Anthem will pay for covered services when these program benefits have been exhausted;
- provided under a U. S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government;
- received from an employer mutual association, trust, or a labor union's medical department; or
- for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities.

Claims and payments

We consider the charge to be incurred on the date a service is provided. This is important because *you* must be actively enrolled on the date the service is provided. Also, the dates of service will affect your payment allowances and other minimums described in the Summary of benefits and in this section.

How Anthem pays a claim

Blue View Vision participating providers

If *you* go to a *provider* that participates with Blue View Vision, *we* will pay the *provider* directly.

Non-participating providers

If *you* go to a non-participating *provider, we* may choose to pay *you*. *We* will pay only after *we* have received an itemized bill and all the information *we* need to process the claim.

In the event that payment is made directly to *you, you* have the responsibility to apply this payment to the claim from the non-participating *provider*. In all cases, *our* payment relieves *Anthem* of any further liability for the service.

When you must file a claim

Network *providers* file claims on your behalf. *You* may have to file a claim if *you* receive care from a *provider* that does not participate in the Blue View Vision Network. To file a claim, follow these 3 steps:

1. Call 800-582-6941 to order a claim form or visit our web site at www.anthem.com for a copy of the claim form.

2. Please include the completed and signed claim form and any itemized bills for covered services. Each itemized bill must contain the following:
   - name and address of the person or organization providing services or supplies;
   - name of the patient receiving services or supplies;
   - date services or supplies were provided;
   - the charge for each type of service or supply; and
   - a description of the services or supplies received.

3. Send the completed claim form and any itemized bills for covered services to:
   Blue View Vision, Attn: OON Claims
   P. O. Box 8504
   Mason, OH 45040-7111

Timely filing of claims

Written notice of a claim is to be made within 20 days after the occurrence or commencement of any loss covered by the vision care plan. However, failure to give this notice shall not invalidate or reduce any claim if the notice is given as soon as reasonably possible. Claim forms will be furnished to *you* if needed within 15 days after this written notice.

Written proof of loss must be furnished within 90 days after the date of service. A proof of loss is not complete unless it is properly filed and contains all information that *Anthem* needs to process the claim. Failure to furnish the proof of loss within this time frame will not invalidate or reduce any claim if the proof of loss is given as soon as reasonably possible. However, no claim will be paid if we receive the proof of loss more than 15 months after the date of service, except in the absence of legal capacity of the *covered person.* All benefits payable for a claim will be payable within 60 days after receipt of the proof of loss.

When your claim is processed

In processing your claim, your vision care plan may use protocols, guidelines or criteria to ensure that coverage determinations are consistently applied. Claims filed as outlined in the "**When you must file a claim**" paragraph of this section will be processed within 30 days of receipt of the claim. We may extend this period for another 15 days if we determine it to be necessary because of matters beyond our control. In the event that this extension is necessary, *you* will be notified prior to the expiration of the initial 30-day period.

Your vision care plan may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by *you* or your provider furnishing the additional information. *You* or your provider must submit the additional information to us within either 15 months of the date of service or 45 days from the date *you* were notified that the information is needed, whichever is later. Once your claim has been processed by your vision care plan, *you* will receive written notification of the coverage decision. In the event of an *adverse benefit determination,* the written notification will include the following:

- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed; and
- a description of your vision care plan's appeal procedures and applicable time limits.

If all or part of a claim was not covered, *you* have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that your vision care plan relied upon in making the coverage decision.

Recovery of overpayment

Anthem shall have the right to recover any overpayment of benefits from persons or organizations that *we* have determined to have realized benefits from the overpayment:

- any person to, or for whom such payments were made;
- any insurance company;
- a facility or provider; or
- any other organization.

You will be required to cooperate with *us* to secure *Anthem's* right to recover the excess payments made on your behalf, or on behalf of *covered persons* enrolled under your family coverage.

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. For more specific information on eligibility, please refer to your group health plan's member booklet.

Ending coverage

When a *covered person* ceases to be eligible or the required premiums are not paid, the *covered person's* coverage will end. Unless otherwise agreed to in writing by *Anthem,* the *covered person's* coverage ends on the last day of the month for which payment is made. The *covered person's* coverage ends on the last day of the month during which eligibility ceases.

Important information about your vision care plan

Statement of ERISA rights

As a participant in this plan *you* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

You may examine, without charge, at your *plan administrator's* office and 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 *plan administrator*. The administrator may make a reasonable charge for the copies.

☞ **Helpful tip:** ERISA generally does not apply to church plans or to governmental plans (such as plans sponsored by city, county, or state governments, or by public school systems).

Plan "fiduciaries"

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

- 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 above rights. 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 or an appeal of a coverage decision, which is denied or ignored, in whole or in part, *you* may file suit in a state or 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 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.

Grievance and appeal process

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your plan or a service you have received. In those cases, please contact Member Service by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file an appeal, which is defined as follows:

Complaints typically involve issues such as dissatisfaction about your health plan’s services, quality of care, the choice of and accessibility to your health plan’s providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by your health 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 *our* 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* may be filed to the following address:

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

Appeal Process

Your vision care plan is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions *you* find unacceptable such as a claim denial. Types of appeals include standard appeals and expedited appeals.

- **Standard appeals** are requests to reconsider coverage decisions of pre-service or *post-service claims;* and
- **Expedited appeals** involve requests to reconsider coverage decisions where the application of pre-service or post-service time periods for making appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain.

How to appeal a coverage decision

To appeal a coverage decision, please send a written explanation of why *you* feel the coverage decision was incorrect. *You* or your authorized representative acting on your behalf may submit the written explanation. Alternatively, this information may be provided to a Member Services representative over the phone. This is your opportunity to provide any new information that *you* feel *we* should consider when reviewing your appeal. Please include with the explanation:

- the patient's name, address and telephone number;
- your identification and group number (as shown on your identification card); and
- in the case of a claim, 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 *us* with your appeal or any questions concerning *your vision care plan* at the following:

For Vision Benefits Issues:
Anthem Blue Cross and Blue Shield/Blue View Vision
Attention: Grievances and Appeals
P.O. Box 27401

Richmond, VA 23279

Telephone:
800-582-6941

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 we 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 an actively practicing practitioner from the same or similar specialty who typically treats the vision condition or provides the procedure or treatment in question, and is not employed by or as a director of the company. An actively practicing practitioner is an individual who provides direct patient care, is board certified or board eligible, and is licensed to practice in Virginia or under similar licensing laws. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

Upon receipt of your appeal, the appeal coordinator who has been assigned to your appeal will send *you* a confirmation letter within 5 business days. *We* will resolve and respond to your appeal within the following time frames:

- 30 days from the receipt of the request to appeal a *pre-service claim;*
- 60 days from the receipt of the request to appeal a *post-service claim;* or
- 72 hours from the receipt of the request to appeal, if an expedited appeal was requested by *you* or the treating *provider*.

We will also provide *you,* free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before *you* receive an *adverse benefit determination* based on new or additional rationale, *we* will provide *you,* free of charge, with the rationale.

When *our* review of your appeal has been completed, *you* will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the plan provision(s) on which the determination is based. *You* will also be entitled to receive, upon request and at no charge, the following:

- reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- the explanation of the scientific or clinical judgment as it relates to the patient's medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- the identification of medical or vocational experts whose advice was obtained by the plan in connection with the claimant's adverse decision, whether or not the advice was relied upon.

Virginia Bureau of Insurance

If *you* have been unable to contact or obtain satisfaction from *Anthem, you* may contact the Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, in Richmond (804) 371-9741, from outside Richmond (800) 552-7945.

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

The Office of the Managed Care Ombudsman

If *you* have any questions regarding an appeal concerning the vision care services that *you* have been provided which have not been satisfactorily addressed by *your vision care plan, you* may contact the Office of the Managed Care Ombudsman for assistance at any of the following:

Address:
The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O.Box 1157
Richmond, VA 23218

Telephone:
804-371-9032
in Richmond
877-310-6560
from outside Richmond

(Note: This number is separate from the Bureau's existing toll-free number and is exclusive to The Office of the Managed Care Ombudsman)

E-Mail:
ombudsman@scc.virginia.gov

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 any questions regarding a complaint and/or an appeal concerning the vision care services that *you* have been provided which have not been satisfactorily addressed by *us, you* may contact the Virginia Department of Health Office of Licensure and Certification for assistance at any of the following:

Address:

Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond, VA 23233

Telephone:
Complaint Hotline: 800-955-1819
Richmond Metropolitan Area: 804-367-2106

Fax:
804-367-2149

E-Mail:
MCHIP@vdh.virginia.gov

Laws governing this vision care plan

This vision care plan is entered into in, and is subject to the laws of, the Commonwealth of Virginia.

This coverage is a Managed Care Health Insurance Program subject to regulation in the Commonwealth of Virginia by both the Virginia State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

Notice in writing

If *we* change the vision care plan, *we* will send *you* written notice. Any notice required under this vision care plan must be in writing. Notice given to your employer will be sent to your employer's address, stated in the group application as provided by the group. Notice given to a *covered person* will be sent, at *our* option, to your employer or to your address as it appears on *our* records. Your employer or a *covered person* may indicate a new address for giving notice.

Cancellation or termination

We can terminate this vision care plan by giving your employer at least 30 days advance written notice. Your employer may cancel this vision care plan on the last day of any month by giving *us* at least 30 days written notice.

We can also terminate this vision care plan when your employer:

- does not pay the appropriate premium when due;
- fails to perform any duties required by the vision care plan;
- commits fraud or misrepresentation with respect to the vision care plan. Additionally, a *covered person's* coverage under the vision care plan may be terminated for fraud or misrepresentation by the *covered person* with regard to his or her coverage;
- fails to comply with *our* underwriting guidelines regarding employer contribution and participation requirements; or

- has no more employees living, residing, or working in *our* service area.

If *we* have issued this policy to an association offering coverage to its membership, *we* may terminate coverage for any subgroup in the association for any of the above occurrences attributable to that subgroup.

Termination of the vision care plan automatically ends your coverage. When the vision care plan is terminated because of an action by your employer, your employer must notify all *covered persons* of the termination of the coverage. However, coverage will end whether or not the notice is given.

Validity of coverage

Your coverage will not be contested after it has been in effect two years, unless premiums have not been paid. Any statement *you* make that *we* may use to contest the validity of your coverage must be written and signed by *you*.

Time limits on legal action

No legal action may be brought against *Anthem* within the 60-day period after proof of loss notice is filed or more than three years after the end of the 90-day period that proof of loss was required to be filed (see "Timely filing of claims" in the **Claims and payments** section). This limit applies to matters relating to this vision care plan, to *our* performance under this vision care plan, or to any statement made by an employee, officer, or director of *Anthem* concerning this vision care plan or the benefits available to a *covered person*.

Limitations of damages

In the event a *covered person* or his representative sues *Anthem,* or any of its directors, officers, or employees acting in his or her capacity as director, officer, or employee, for a determination of what coverage and/or benefits, if any, exist under this vision care plan, the damages shall be limited to the 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 contractual damages that may be available to *you* or your representative.

Anthem's continuing rights

On occasion, *we* may not insist on your strict performance of all terms of this vision care plan. This does not mean *we* waive or give up any future rights *we* have under this vision care plan.

Anthem's relationship to providers

The choice of a vision care *provider* is solely the *covered person's*. Providers are neither Anthem employees nor agents. We can contract with any appropriate provider to provide services to you. Our inclusion or exclusion of a provider in any network is not an indication of the provider's quality or skill. We make no guarantees about the health of any providers. We do not furnish covered services but only make payment for them when received by covered persons.

We are not liable for any act or omission of any *provider,* nor are *we* responsible for a *provider's* failure or refusal to render covered services to a *covered person.*

Assignment of payment

A *covered person* may not assign the right to receive payment for covered services. Prior payments to anyone, whether or not there has been an assignment of payment, shall not waive or otherwise restrict, Anthem's right to direct future payments to a *covered person* or any other entity.

Once covered services are rendered by a provider, Anthem will not honor requests not to pay the claims submitted by the provider. Anthem will have no liability to any person because it rejects the request.

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.

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 authorization in advance.

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.

We, us, our, Anthem
is Anthem Blue Cross and Blue Shield.

You
the enrolled employee.

Your vision care plan
Anthem vision care plan.

Index

Page

Appeals 11
Canceling coverage (or ending coverage) 8
Changing your coverage 8
Children (or dependents) 8
Claim filing 5
Eligibility for coverage 8
Exclusions 4
Filing a claim 6
Grievances (or appeals) 11
Network (or in-network and out-of-network) 1
Out-of-network 1
Phone numbers ..... inside front cover
Spouses (or dependents) 8
Summary of benefits 2

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

Your eyewear discounts/costs at participating Blue View Vision provider offices are as follows:

Service	Member Cost
Frame	Discount applied to balance over plan allowance
Lens Options (Eyeglass lens copayment applies)	
UV Coating	$15
Tint (Solid and Gradient)	$15
Standard Polycarbonate (for dependents over the age of 19 and adults)	$40
Transitions Lenses (for dependents over the age of 19 and adults)	$75
Other Photochromic Lenses	$75
Standard Progressive (Add-on to bifocal)	$65
Premium Progressive tier 1	$85
Premium Progressive tier 2	$95
Premium Progressive tier 3	$110
Standard Anti-Reflective Coating	$45
Premium Anti-Reflective Coating tier 1	$57
Premium Anti-Reflective Coating tier 2	$68
Other Add-ons and Services	Discount available
Contact Lenses	
Conventional (non-disposable) – materials only	Discount applied to balance over plan allowance

Plus, Anthem members have access to discounts on laser vision correction surgery and other vision discounts through SpecialOffers@Anthem.

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

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. an independent licensee of the Blue Cross and Blue Shield Association.

® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

01/01/2016

Date created 04/13/16 08:36:24

20160101_VBVAUnitedMethHRA