Blue Cross Blue Shield of Georgia
Vision Certificate of Coverage

Blue Cross Blue Shield of Georgia
Blue View Vision
COBB EMC

Blue Cross and Blue Shield of Georgia, Inc.
Corporate Headquarters
3350 Peachtree Rd
Atlanta, GA 30326

VISION MASTER GROUP CONTRACT
Blue Cross and Blue Shield of Georgia, Inc.
(herein called BCBSGA)
an Independent Licensee of the
Blue Cross and Blue Shield Association having issued a

Vision Master Group Contract

To
COBB EMC

hereby certifies that

1. The persons and their eligible family members (if any) whose names are on file at the office of the plan administrator as being eligible for coverage, have had the required application for coverage accepted and subscription charge received by BCBSGA. These persons are covered under and subject to all the exceptions, limitations, and provisions of said Vision Master Group Contract (also called the *group contract*) for the benefits described herein;
2. Benefits will be paid in accordance with the provisions and limitations of the *group contract*; and
3. BCBSGA has delivered to the plan administrator the *group contract* covering certain persons and their eligible family members (if any) as *members* of this group program.

The *group contract* (which includes this *certificate*, *member* and *group* applications, and any endorsements, amendments or riders) constitutes the entire *group contract*. All rights which may exist, arise from and are governed by this *group contract*, and this *certificate* does not constitute a waiver of any of the terms. The *group contract* may be inspected at the office of the plan administrator.

Coverage under this *certificate* will be effective and will continue in effect in accordance with the terms, provisions and conditions of the *group contract*. This *certificate* replaces and supersedes all contracts and/or certificates which may have been issued previously by BCBSGA through the plan administrator.

The *certificate* was issued in the state of Georgia. Its laws and rules will govern in resolving any questions about the *certificate*.

Introduction

Welcome!

Thank you for choosing Blue Cross and Blue Shield of Georgia (BCBSGA) for your vision care coverage. The following materials make up your *plan*:

- this booklet (your *certificate*)
- your application
- any endorsements, amendments or riders

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

- the *group contract* (you may request a copy of this from your *group's* human resources or benefits department)
- the *group's* master application

This *certificate* contains important information about your *plan*, such as what vision care services are covered and how they will be covered. It replaces any older version of the *certificate* you may have for this vision plan.

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

Please review this *certificate* so you know where to find the information that you may need. Store it in a convenient place and refer to it whenever you have questions about your vision care coverage. See the section Contact Us for information on important phone numbers, addresses and websites.

Notice: The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

Jeffrey P. Fusile,
President

Contact Us

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

Member Services

Please send your general inquiries, suggestion or comments to:
BCBSGA Blue View Vision
P.O. Box 8504,
Mason, OH 45040-7111
Phone: (866) 723-0515

Please send claims to:
BCBSGA Blue View Vision
Attention: Claims
P.O. Box 8504
Mason, OH 45040-7111
Phone: (866) 723-0515

Please send appeals to:
BCBSGA Blue View Vision
Attention: Appeals
555 Middle Creek Parkway
Colorado Springs, CO 80921
Phone: (866) -723-0515

Hours of operation

Monday – Saturday: 8:30 a.m. to 11:00 p.m. Eastern Time
Sunday: 11 a.m. to 8:00 p.m. Eastern Time

Visit Us Online

Learn more about Blue View Vision, our network providers, and more by visiting us at: www.bcbsga.com

How to Get Language Assistance

BCBSGA is committed to communicating with our members about their health plan, no matter what their language is. We employ a language line interpretation service for use by all of our customer service call centers. Simply call the member services phone number above and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting member services. TTY/TDD services are also available by dialing 711. A special operator will get in touch with us to help with your needs.

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 on the back of your id card or in your Certificate of Coverage.

Table of Contents

Schedule of Benefits

This Schedule of Benefits is just a summary of your benefits. Please refer to the Covered Services section of this *certificate* for a more complete explanation of the specific vision services covered by the *plan*. All *covered services* are subject to the conditions, exclusions, limitations, terms and provisions of the *plan*.

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 may be reduced when you use a *non-network provider*. See the section How Your Plan Works for more information.

Vision Care Services	Benefit Frequency	In-Network	Out-of-Network Reimbursement
Routine Eye Exam	Limited to one exam per member every calendar year	$10 copayment	up to $48
Standard Plastic Lenses	Limited to one set of lenses every calendar year		
• Single Vision lenses		$10 Copayment	up to $36
• Bifocal lenses		$10 Copayment	up to $54
• Trifocal lenses		$10 Copayment	up to $69
• Lenticular lenses		$10 Copayment	up to $80
Lenses include factory scratch coating. Polycarbonate lenses and Photochromic lenses are also available for dependents under 19 years old at no extra cost when received In-Network.			
Frame	Limited to one frame every two calendar years	no copayment $110 allowance	up to $64
Prescription Contact Lenses	Once every calendar year		
• Non-Elective Contact Lenses		covered in full	up to $210
• Elective Contact Lenses (traditional or disposable)		no copayment $100 allowance	up to $87
Note: Your lens benefit may apply toward non-elective or elective contact lenses, or eyeglass lenses. If you elect covered non-elective contact lenses or elective contact lenses within a stated benefit period, no benefits will be available for covered lenses will be available until the above stated benefit frequency has passed.			

Definitions

This section defines terms that have special meanings. If a word or phrase has a special meaning it will be italicized. 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.

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

Coinsurance. The percentage of the *plan's maximum allowable amount* for which you are responsible to pay for *covered services*. See the Schedule of Benefits for your coinsurance amounts.

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

Covered Services. Services, supplies or treatment that are listed as covered in this *certificate.* A covered service is incurred on the date the service, supply or treatment was provided to you. In order 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;
- given while coverage under this *certificate* is in force;
- Within the *maximum allowable amount*;
- Not specifically excluded or limited by the *certificate*;
- Specifically included as a benefit within the *certificate*.

Deductible. The dollar amount for which you are responsible before we start to pay for *covered services*. See the Schedule of Benefits for your deductible amount.

Dependent. A member of the *subscriber's* family that may be covered under this *plan*. See the Eligibility and Enrollment Section of this *certificate* for more information on which family members are considered dependents.

Effective Date. The date your coverage begins under this *plan*.

Group. The employer or other entity or trust that has entered into a *group contract* with us**.**

Group Contract (or contract). The contract between BCBSGA and the *group*. It includes this *certificate*, your and your *group's* applications, any supplemental application or change form, your ID card, and any amendments, endorsements or riders.

Last Date of Service. The period of time that benefits and frequencies are tracked. When you get a *covered service*, you must wait a period of time from the last date of service before you we will pay for the *covered service* again. See the Schedule of Benefits for the benefit frequencies.

Maximum Allowable Amount. The maximum amount we will pay for *covered services*. See the section How Your Plan Works for more information on how we determine the maximum allowable amount.

Member. A *subscriber* or *dependent* who meets the eligibility conditions, has applied for coverage, been accepted by us for coverage, and for whom any applicable *premiums* has been paid.

Network Provider. A *provider* that has an agreement with us to service the network associated with this *plan*. See the section How Your Plan Works for more information on network providers.

Non-Network Provider. A *provider* who has not agreed to service the network associated with this *plan*. See the section How Your Plan Works for more information on non-network providers.

Plan. The entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this *certificate*, your and your ***group's*** application, and amendments, endorsements or riders, and the *group contract*.

Premium. The periodic charges that the *group* must pay us to maintain coverage. You may be responsible to pay a portion of the premium. See your ***group's*** human resources or benefits department for more information.

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

Subscriber. An employee, retiree, or other member of the *group* that is eligible to enroll in this *plan*. Subscriber eligibility requirements are determined by the *group*. See the section Eligibility and Enrollment for more information.

Eligibility and Enrollment

This section will tell you who is eligible to enroll for coverage, as well as when you can enroll for coverage.

Eligibility

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

- be an employee, retiree, or other member of the *group;*
- meet the eligibility criteria established by the *group* and stated in the *group contract*;
- be entitled by the *group* to participate in the *group's* benefit; and
- be *actively at work* and have met any probationary or waiting period established by the *group*.

Dependents. To enroll your *dependents*, you (the *subscriber*) must list your *dependents* on the application for enrollment. The following members of your family may be eligible to enroll as a *dependent*:

- Your legal spouse. For more information on spousal eligibility, contact your group. If spouses are not covered under this plan, any reference to spouses throughout this certificate do not apply.
- Children. Your and your spouse's children up to age 26. This includes:
  - natural children or stepchildren;
  - legally adopted children or children placed for adoption;
  - children for whom you are the legal guardian; or
  - children for whom you have been court-ordered to provide coverage.
- Disabled Children. Your and your spouse's children may continue to be covered under this *plan* past the above stated age limit if:
  - they are unmarried and incapable of self-support due to a mental or physical handicap;
  - are financially dependent on you or your spouse for support and maintenance; and
  - were enrolled and disabled prior to reaching the age limit under this plan.

  Talk to your *group's* human resources or benefits department for more information about disabled dependent coverage. You will be asked to provide proof of the child's disability. After two years from when you initially provide such proof, we may ask for continued proof of the disability, but no more than once a year.

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

Adding a Child due to Award of Legal Custody or Guardianship. If you or your 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 will be effective on the date the court granted legal custody or guardianship.

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 in this *plan*, you may enroll the child at any time without regard to any open enrollment limits. We will provide the benefits of this *plan* in accordance with the applicable requirements of such order. A child's coverage will not extend beyond the limiting age stated in this *certificate*.

Enrollment

Initial Enrollment. The *group* will have an initial enrollment period for newly eligible persons and their *dependents* to enroll for coverage. You may need to meet a waiting period established by the *group*

before you can enroll for coverage. See your *group's* human resources or benefits department to determine if there are any waiting periods.

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

Open Enrollment. Open enrollment is the period of time during which *eligible persons* and their *dependents* can apply for or change their coverage. Open enrollment happens at least once per year. See your *group's* human resources or benefits department for more information on open enrollment.

Special Enrollment. Your plan elections chosen during initial or open enrollment are intended to remain the same until the next open enrollment period. However, there may be times when you or your *dependents* can enroll for coverage outside of an open enrollment period. This is allowed if you have certain qualifying events happen. Qualifying events are:

- You or your *dependent* did not enroll for coverage because you had coverage under another plan and have since become ineligible for that plan (for any reason other than non-payment of premium or due to fraud or intentional misrepresentation of material fact). You must request enrollment within 31 days after this qualifying event.
- You or your *dependent* lost coverage under Medicaid or a Children's Health Insurance Program (CHIP); or you or your *dependent* became eligible for a subsidy (state premium assistance program). You must request enrollment within 60 days after this qualifying event.
- You have a change in the number of *dependents* due to marriage, birth, adoption, court order, legal guardianship or death. You must request enrollment within 31 days after this qualifying event.

Nondiscrimination. No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Notice of Changes

You are responsible to notify your *group* of any changes which will affect your or your *dependent's* eligibility under this *plan*. This includes a change in address or a change in the number of your *dependents*. The *group* is then responsible to notify us of any changes according to the terms of the *group contract*. Changes to your or your *dependent's* eligibility may result in a change in the *premium*. If your *group* fails to notify us of your changes in eligibility or to pay the required *premium*, it does not obligate us to pay for your vision care.

Statements and Forms. You must complete and submit any necessary applications, or other forms or statements, we may reasonably request. Any rights to benefits under this *plan* are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by you may result in termination of coverage as provided in the section Termination and Continuation of this *certificate*. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply to fraudulent misstatements.

Effective Date of Coverage

Your *effective date* is the date coverage begins under this *plan*. Your *effective date* is listed on your ID card for this *plan*. See your *group's* human resources or benefits department for more information on your *effective date*.

Termination and Continuation

Termination

This section explains how your coverage may end. Upon your *group's* anniversary date, this coverage will renew at their option as long as *premiums* are paid. Except otherwise noted below, coverage will end on the last date of the month in which the event occurs.

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

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

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

If Your Group No Longer Meets the Requirements of the Group Contract. You coverage will end if your *group* no longer meets the requirements of the *group contract* (for example, if the *group* no longer is able to meet the participation rules of the *group contract*). We will send the *group* written notice at least 60 days before coverage will end letting them know they are not in compliance with the *group contract*.

Fraud, Intentional Misrepresentation, Misuse of an ID Card. We will cancel this coverage if you or the *group* participates in any kind of intentional misrepresentation of material fact (knowingly provide false information) or fraud during the application and/or enrollment process. We may also cancel your coverage for other types of fraud, such as if you allow any other person to use your ID card to obtain benefits, or if you use another *member's* ID card (including one of your *dependent's* ID card) to obtain benefits. You will be held liable for any payments we make as a result of fraud. For any fraud or intentional misrepresentation, coverage will end on the date we send the written notice of cancellation.

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

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

Reinstatement. If coverage lapses because the *premium* has not been paid within the time allowed, you will not be reinstated automatically. You may have to reapply for your coverage. If this coverage ends because of an inadvertent clerical error, reapplication is not necessary. Your coverage will not be negatively affected as a result of the *group's* clerical error. However, the *group* is liable to us if we incur financial loss as a result of their clerical error.

Continuation of Coverage

State Continuation of Coverage. 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 covered *dependents* for the rest of the month of termination and three additional months by paying the appropriate premium.

This benefit entitles each *dependent* 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 *subscribers* or their *dependents*. To elect this benefit you must notify your *group's* human resources or benefits department within 30 days of the date your coverage would otherwise end that you wish to continue your coverage. You must also 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. State 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 your *dependents* that 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 your *group's* human resources or benefits department.

Please note: COBRA applies to employer sponsored plans other than church employer groups. If you have questions, please contact your *group's* human resources or benefits department. Members of church employer groups are eligible for state continuation of coverage. See State Continuation of Coverage above or talk to your *group's* human resources or benefits department for more information.

Qualifying Events for COBRA. COBRA is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for the continuation coverage.

This benefit entitles each member of your family (who is enrolled in the *plan*) to elect COBRA independently. This means each qualified beneficiary has the right to elect or not elect continuation at the time of enrollment. *Subscribers* may elect COBRA on behalf of their *dependents*. Parents or legal

guardians may elect COBRA on behalf of their children. A child born to, or placed for adoption with, a *subscriber* during the period of continuation coverage is also eligible to elect COBRA.

Initial Qualifying Event	Length of Availability of Coverage
For Subscribers: Voluntary or involuntary termination (other than gross misconduct) or loss of coverage under the group's plan due to reduction in work hours.	18 months
For Dependents:	
• A subscriber's voluntary or involuntary termination (other than gross misconduct) or loss of coverage under the group's plan due to reduction in work hours.	18 months
• Subscriber becomes entitled to Medicare.	36 months
• Divorce or legal separation.	36 months
• Death of a subscriber.	36 months
For Dependent Children: Loss of dependent child status.	36 months

COBRA coverage will end before the end of the time frames listed above if you become eligible for Medicare benefits. In that case, a qualified beneficiary (other than the Medicare beneficiary) is entitled to continuation coverage for no more than a total of 36 months. For example, if you become eligible for Medicare before termination of employment or reduction in work hours, COBRA for your spouse and children can last up to the 36 months after the date you become eligible for Medicare.

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

Second Qualifying Event. If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA coverage, your *dependents* can receive up to 18 additional months of coverage. Coverage will not exceed 36 months from the date of the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your *dependents* to lose coverage under the plan if the first qualifying event had not occurred.

Notification Requirements. The *group* will offer COBRA coverage 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 of a reduction in hours worked, death of a subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the ***subscriber's*** becoming eligible for Medicare benefits (under Part A, Part B or both), the *group* will notify the COBRA administrator (such as human resources or their external vendor) of the qualifying event.

You must give notice of some qualifying events. For other qualifying events (such as divorce or legal separation, or a dependent child losing their dependent status), you must notify the *group* within 60 days after the qualifying event occurs.

Electing COBRA Coverage. To continue your coverage, you or an eligible *dependent* must make an election within 60 days of the date your coverage would otherwise end, or the date the *group* notifies you or your *dependent* of this right, whichever is later. You must pay the total premium appropriate for the type of coverage you choose to continue. If the premium rate changes for active associates, your monthly premium will also change. The premium you must pay cannot be more than 102% of the premium charged for employees with similar coverage. Premiums must be paid to the *group's* human resources or benefits department within 30 days of the date due, except that the initial premium payment must be made before 45 days after the initial election for continuation, or your continuation rights will be forfeited.

Disability Extension of 18 Month Period of Continuation. For *subscribers* who are determined at the time of the qualifying event to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and subscribers who become disabled during the first 60 days of COBRA coverage, coverage may continue from 18 to 29 months. These *subscriber's dependents* are also eligible for the 18 to 29 month disability extension. This also applies to any covered *dependent* that is found to be disabled. This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the *group* can charge 150% of the premium for months 19 through 29. This would allow coverage to be provided in the period between the end of the 18 months and the time that Medicare begins coverage for the disabled at 29 months. If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the *group's* human resources or benefits department of that fact in wring within 30 days after the Social Security Administration determination.

Trade Adjustment Act Eligible Individual. If you do not initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be initially eligible for COBRA under this plan, you will be entitled to another 60 day period in which to elect COBRA coverage. This second 60 day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

When COBRA Coverage Ends. COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- a *member* reaches the end of the maximum coverage period;
- a *member* fails to pay a required premium on time;
- a *member* becomes covered under any other group health plan after electing COBRA;
- a *member* becomes entitled to Medicare after electing COBRA; or
- the *group* terminations all of its group benefit plans.

If You Have Questions. Questions concerning your *group's* plan and your COBRA continuation coverage rights should be address to your *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 the Regional and District EBSA offices are available through their website.

Continuation of Coverage Age 60 and Over. A *subscriber* and their 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 the *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 that covers 20 or more employees; and
- you must have been continuously enrolled for at least 6 months under this *plan*.

This continuation benefit is NOT available if:

- your employment is terminated voluntarily for other than health reasons;
- the health plan enrollment was termination because you failed to pay a premium or premium contribution;
- the health plan enrollment is terminated and replaced without interruption by another group contract;
- health insurance is terminated for the entire class of employees to which you belong;
- the *group* terminated health insurance for all employees; or
- your employment was terminated due to reasons which would cause a forfeiture of unemployment compensation under 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 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 *group contract* is terminated. If the *group contract* is replaced, coverage will continue under the new group plan;
- the date you become insured under any other group health plan;
- the date you or your divorced or surviving spouse becomes eligible for Medicare.

Extension of Benefits in Case of Total Disability. If the *group contract* is terminated for non-payment of premiums, or is terminated by us (with at least 60 days written notice), or if the *group* terminates the *group contract* for any reason, then 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 12 months from the date of termination of the *group contract*.

NOTE: We consider total disability a condition resulting from disease or injury where:

- the *subscriber* 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 *subscriber'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. 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. Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the *subscriber* or their *dependents* may have a right to continue health care coverage under the *plan* if the *subscriber* must take a leave of absence from work due to a military leave. Employers must provide a cumulative total of five years, and in certain instances more than five years, of military leave.

During a military leave covered by USERRA, the law requires employers to continue to provide coverage under this *plan* for its members. The coverage provided must be identical to the coverage provided to similarly situated, active *subscribers* and *dependents*. This means that if the coverage for similarly

situated, active *subscribers* and *dependents* is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your *dependents* by notifying your *group* in advance and submitting payment of any required contribution for health coverage. This may include the amount the *group* 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. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage during a Military Leave. Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the *group* following completion of your military leave. *Subscribers* must return to work within:
    a. The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
    b. 14 days after completing military service for leaves of 31 to 180 days;
    c. 90 days after completing military service for leaves of more than 180 days.
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave. Regardless of whether you continue coverage during your military leave, if you return to work your and your ***dependent's*** health coverage will be reinstated under this plan if you return within;

- the first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
- 14 days of completing your military service for leaves of 31 to 180 days; or
- 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

- 2 years; or
- as soon as reasonably possible if, for reasons beyond your control you cannot return within 2 years, because you are recovering from such illness or injury.

If your coverage under the *plan* is reinstated, all terms and conditions of the plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any waiting periods will apply only to the extent that they applied before your military leave.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this *plan* will not provide coverage for any illness or injury caused or aggravated by your military service, as indicated in the Covered Services section.

Family and Medical Leave Act of 1993. A *subscriber* who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this plan during their leave .We will not consider the *subscriber* and his or her *dependents* ineligible because the *subscriber* is not at work.

If the *subscriber* ends their coverage during the leave, the *subscriber* and any *dependents* who were covered immediately before the leave may be added back to the plan when the *subscriber* returns to work without medical underwriting. To be added back to the plan, the *group* may have to give us evidence that the Act applied to the *subscriber*. We may require a copy of the health care provider statement allowed by the Act.

How Your Plan Works

This section tells you how we pay for your vision care. It will also tell you more about how your out of pocket costs are determined, and how your choice of *provider* may affect those out of pocket costs. See the Schedule of Benefits will tell you the specific amounts for which you are responsible to pay for your vision care.

Choosing a Provider

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

> **Important Note:** We do not restrict or interfere with your right to select the *provider* of your choice, but your benefits may be reduced when you use a *provider* who is not a *network provider*. Please call us or visit our website listed in the Contact Us section if you want help in finding a *network provider*.

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

Non-Network Providers. *Non-network providers* are vision care *providers* that did not agree to participate in our Blue View Vision network. They have not agreed to any negotiated rate and do not have a provider contract with us. *Non-network providers* can charge you their usual amount for *covered services*. As such, using a *non-network provider* will typically increase your out of pocket costs.

Benefit Maximums, Allowances and Frequency Limits

Maximum Allowable Amount. The *maximum allowable amount* is the most we will pay for *covered services*. *Network providers* have agreed to accept the *maximum allowable amount* as payment in full for *covered services*. You may be responsible to pay for a portion of the *maximum allowable amount*, such as the *copayment*. Your portion of the *maximum allowable amount* is stated in the Schedule of Benefits. *Non-network providers* have not agreed to accept our *maximum allowed amount* as payment in full and may charge you their usual amount for services and supplies.

Allowances/Reimbursement Amounts. You may have an allowance or reimbursement amount to apply to services or supplies under this *plan*. This means you will have a set dollar amount to use toward the service or supply. If the service or supply costs more than the allowance or reimbursement, you will be responsible to pay for the difference. Allowances and reimbursement amounts are stated in the Schedule of Benefits.

When you use an allowance or reimbursement amount at a *non-network provider*, you will be responsible to pay for all charges at the time of service. You will then need to submit a claim to us to obtain the allowance or reimbursement. See the How to Submit a Claim section for more information.

Benefit Frequency Limits. The benefit frequency limit is the number of times we will pay for a *covered service* under this *plan*. You are responsible to pay all charges for services or supplies that are received more than the allowed frequency limits. Benefit frequencies are stated in the Schedule of Benefits.

Premiums

Premiums are the monthly charges that your *group* has to pay us to keep your coverage in effect. Your *group* is responsible to pay us any *premiums* on your behalf. You may be required to pay a portion of the *premium*. See your *group's* human resources or benefits department for more information on *premiums*.

Covered Services

This section tells you what vision care is covered under this *plan*. All *covered services* are subject to terms, conditions and limitations of this *plan*, including the exclusions listed in the Exclusions section,

> **Note:** Your out of pocket costs may be higher if you receive care from a *non-network provider*. See the section How Your Plan Works for more information on *providers* and how to find a *network provider*.

See the Schedule of Benefits for *copayments*, allowances and benefit frequencies for *covered services*.

Routine Eye Exam. Your plan covers a complete routine eye exam with dilation, as needed. The exam is used to check all aspects of your vision. Coverage for an eye exam does not include a contact lens fitting fee.

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

Eyeglass Lenses. You have a choice in your eyeglass lenses. Lenses include factory scratch coating at no additional cost. *Dependents* under age 19 may also receive polycarbonate and photochromic lenses at no additional cost when received from a *network provider*. Covered lenses include plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT25-28)
- Progressives
- Lenticular
- Photochromic lenses (for members age 19 and older)

Contact Lenses. Your lens benefit may apply to eyeglass lenses, elective contact lenses, or non-elective contact lenses. If you get elective or non-elective contact lenses, an eyeglass lens benefit will not be available until your benefits renew. The Schedule of Benefits tells you the benefit frequency for lenses.

Elective Contact Lenses. These are lenses that you choose for comfort or appearance.

Non-Elective Contact Lenses**.** These are contact lenses that are prescribed for the following conditions only:

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

Note: We will not pay for non-elective contact lenses for any *member* that has had elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK

Contact Lens Fitting Fees. Professional fitting fees are not a *covered service*. You are responsible for 100% of the fitting fee at the time of service. However, if the benefit has been paid toward your contact lenses and not all of the allowance was used, the leftover amount may be applied to fitting fees. If your allowance does not pay for all of the fitting fees, you will be responsible to pay for the difference. Payment for fitting fees will be paid directly to your prescribing *provider*.

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:

- **Not specifically listed**. Services not listed in the Covered Services section of this *certificate*.
- **Sunglasses**. Sunglass lenses or accompanying frames.
- **Excess Amounts**. Any amounts that go over the benefit maximums, allowances, or frequencies stated in this *certificate*.
- **Contact Lenses Fittings**. Standard and Premium contact lens fittings are not covered. This includes fittings for more complex applications, including toric, bifocal/multifocal, cosmetic color, post-surgical and gas permeable lenses. It also includes extended/overnight wear lenses.
- **Cosmetic Options**. Cosmetic lens options not specifically listed in the Schedule of Benefits or the Covered Services section of this *certificate*. This includes non-prescription eyewear and lenses, plano lenses or lenses that have no refractive power.
- **Medical or Surgical Treatments**. Any diagnostic testing or medical or surgical treatment of the eyes, including any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and/or astigmatism. We also will not cover any contact lenses or eyeglasses required as a result of this surgery.
- **Lost or Broken Lenses or Frames**. Any lost or broken lenses or frames, unless you have reached a new benefit period.
- **Charges over the Maximum Allowable Amount**. We will not pay charges that are more than the *maximum allowable amount* under this *plan*.
- **Uninsured**. Services received before your *effective date* or after this coverage ends.
- **Voluntary Payment**. Services for which you are not legally obligated to pay, for which you are not charged, or for which no charge is made in the absence of insurance coverage.
- **Work-Related**. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation law or similar law, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those condition pursuant to any workers' compensation law or similar law, we will provide the benefits of this plan for such condition, subject to our right to a lien or other recovery applicable law.
- **Government treatment**. Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this *plan* is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.
- **Non-Licensed Vision Care Providers**. Treatment or services rendered by non-licensed providers is not covered. Also, treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed vision care provider under the supervision of a licensed physician or licensed vision care provider, except as specifically provided or arranged by us.
- **Services of Relatives**. Professional services or supplies received from a person who lives in your home or who is related to you by blood or marriage.
- **Hospital Care**. Inpatient or outpatient hospital vision care.
- **Orthoptics**. Orthoptics or vision training and any associated supplemental testing.
- **Missed or Cancelled Appointments**. We will not pay for appointments a *member* has missed or cancelled.
- **Services or Supplies Combined with Discounts.** We will not pay for services or supplies when combined with any other offer, coupons or in-store advertisement. We will also not pay for certain brands of frames where the manufacturer does not allow discounts.

How to File a Claim

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

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

Claim Forms. Once you give us notice of your claim, we will provide you with the claim forms you will need within 15 days after you notify us. The claim form will have instructions on how to fill it out and where to send it to us. If you do not receive the claim form within 15 days of your notice, you may send us other written proof of your loss instead. An example of other proof of loss would be an itemized bill from your *provider*. To make it easier to process your claim, the other proof of loss should include the following:

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

Proof of Loss. Your written proof of loss as described above should be sent to us within 90 days from the date you had your vision care. If it is not reasonably possible to provide us your written proof of loss within this time, we will not invalidate or reduce your claim. However, you must send it as soon as reasonable possible, and in no event no later than one year from when it was due, unless you are legally incapacitated.

Notice of claim, claim forms and itemized bills can be sent to the following address:

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

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

Payment of Claims. We will pay claims directly to *providers* if they have an assignment of benefits on file with us. If the *provider* does not have an assignment of benefits on file then we will pay claims to you or your designated beneficiary.

General Provisions

Entire Contract. Your *plan* is the entire contract of insurance. Your *plan* is made up of this *certificate*, the *group contract*, the *group's* and, if any, your applications. It also includes any riders, endorsements, amendments or other attachments. No agent or employee of the *plan* is authorized to change the form or content of this *plan* or waive any of its provisions. And executive officer must endorse any change that we issue for it to be valid. All statements made by you or the *group* shall be deemed representations and not warranties. No written statement made by you will be used in any contest for a claim unless a copy of the statement is furnished to you, or to your beneficiary or personal representative.

Incontestability. The validity of this *plan* will not be contested, except for nonpayment of *premiums*, after it has been in force for two years from its date of issue. No statement made by you or your *dependents* relating to you or your *dependent's* insurability will be used to contest the validity of this *certificate* unless the statement is contained in a written instrument signed by you or your *dependents*.

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

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

Right of Recovery. When we overpay a claim, we have the right to recover our overpayment. We may recover our overpayment from you, the person or *provider* we paid, or another plan. We may deduct any overpayment from pending or future claims.

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

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

Vision Services. We are not liable for providing *covered services*, only the payment of them. You 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.

Conformity with Law. The laws of the State of Georgia will be used to interpret any part of this *plan*. Any provision of the *plan* which is in conflict with the laws of the State of Georgia or with federal law will be amended to conform to the minimum requirements of such laws.

Modifications. We may change this *plan*, including the *premiums*, at any time by providing written notice to the *group* at least 30 days before the change takes effect.

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

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

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

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

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

Statement of ERISA Rights

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

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

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

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

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

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

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

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

Complaint and Appeals Procedures

This section will tell you how to contact us when you have questions, suggestions, concerns or complaints. Please have your identification number (found on your ID card) handy when you contact us. We use this number to locate your information with the least amount of inconvenience to you. Our member services are available to help you with a variety of things, including:

- answer questions you may have about your benefits, our provider network, information about claims, and other BCBSGA procedures;
- direct your suggestions to the appropriate person within BCBSGA; or
- provide assistance to you when you want to file a complaint or an appeal.

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

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

Complaints

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

If you have a complaint or problem concerning benefits or services, please contact us. You may submit your complaint by letter or by telephone. You are encouraged to file complaints within 60 days of an initial, adverse action, but must file within 6 months after receipt of notice of the initial action. The time required to review complaints does not extend the time in which appeals must be filed.

Appeals

An appeal is a formal request from you asking us to change the decision we made on a claim or a benefit determination. If you are notified in writing that we denied your claim, or any other adverse decision by us, you will be advised of your right to an internal appeal.

The appeals process may be initiated by you, your authorized representative, or a *provider* acting on your behalf. We encourage appeals to be submitted to us within 60 days after you receive our written notice that we denied your claim or other request, but must be filed no later than 6 months. The request should include any information or documents you feel would be important in our decision of your appeal. A You are entitled to receive, upon request and free of charge, reasonable access to, and copies of any documents, records, and other information relevant to your appeal.

The individuals responsible for reviewing your appeal will not be the same individuals who made the initial decision in your claim or benefit determination. Nor will they be subordinates of the initial decision makers and no deference will be given to the initial decision. Within a reasonable period of time, but no later than 30 days after receiving a written or an oral request for an appeal, we will send you or your authorized representative a written decision.

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

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

It is important that we treat you fairly. That is why we follow Federal civil rights laws in our health programs and activities. We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language is not English, we offer free language assistance services through interpreters and other written languages. If you are interested in these services, contact our member services at the number in the Contact Us section of this certificate. If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator at Blue Cross Blue Shield of Georgia, Blue View Vision, PO Box 8501, Mason, OH 45040-7111 or by calling (866) 723-0515 (TTY/TDD: 711) or email coordinator@BCBSGA.com. Or you may file a complaint with the U.S. Department of Health and Human Services at:

Us Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-868-1019 (TTD: 1- 800-537-7697)
Website: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.


BlueCross
BlueShield
of Georgia