Vision Evidence of Coverage

University of Richmond

Take Control of Your Health

Your Health Care Plan
HealthKeepers, Inc.
Blue View Basic Vision Care Evidence of Coverage

Your vision care benefits are provided through a vision plan issued by HealthKeepers, Inc. to go along with the health benefits provided by your employer’s self-funded health plan. This Vision Evidence of Coverage (“EOC”) fully explains your vision care benefits and how you can maximize them. Treat it as you treat the owner’s manual for your car - store it in a convenient place and refer to it whenever you have questions about your vision care coverage.

Important phone numbers
Member Services
804-358-7390
in Richmond
800-421-1880
from outside Richmond

How to obtain language assistance
HealthKeepers is committed to communicating with our members about their health plan, regardless of their language. HealthKeepers 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.

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.
Saturday
9:00 a.m. to 1:00 p.m.

Key words
There are a few key words you will see repeated throughout this EOC. We’ve highlighted them here to eliminate confusion and to make the EOC easier to understand. In addition, we have included a Definitions section on page 15 that lists various words referenced. A defined word will be italicized each time it is used.

HMO, we, us, our
Refers to HealthKeepers, Inc.

Subscriber
The eligible employee as defined in the agreement who has elected coverage for himself/herself and his/her dependents (if any) who meet the eligibility requirements of the self-funded health plan EOC and enrolls in the HMO.
**Member**
Any subscriber or enrolled dependent.

**You, your**
Any member.

**Your vision care plan**
Blue View Vision care plan offered with health plan issued by HealthKeepers, Inc.

**Copayment**
The fixed dollar amount you pay for some covered services.

**Coinsurance**
The percentage of the allowable charge you pay for some covered services.
# Table of contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>How your vision care plan works</td>
<td>1</td>
</tr>
<tr>
<td>Choose a vision care provider</td>
<td>1</td>
</tr>
<tr>
<td>Out-of-network care</td>
<td>1</td>
</tr>
<tr>
<td>What is covered</td>
<td>2</td>
</tr>
<tr>
<td>Summary of benefits</td>
<td>2</td>
</tr>
<tr>
<td>What is not covered (Exclusions)</td>
<td>3</td>
</tr>
<tr>
<td>Claims and payments</td>
<td>4</td>
</tr>
<tr>
<td>How the HMO pays a claim</td>
<td>4</td>
</tr>
<tr>
<td>When you must file a claim</td>
<td>4</td>
</tr>
<tr>
<td>Changing your coverage</td>
<td>7</td>
</tr>
<tr>
<td>Who is eligible for coverage</td>
<td>7</td>
</tr>
<tr>
<td>Ending coverage</td>
<td>7</td>
</tr>
<tr>
<td>Important Information about your vision care plan</td>
<td>8</td>
</tr>
<tr>
<td>Complaint and appeal process</td>
<td>9</td>
</tr>
<tr>
<td>Definitions</td>
<td>15</td>
</tr>
<tr>
<td>Index</td>
<td>17</td>
</tr>
<tr>
<td>Vision discount program</td>
<td>18</td>
</tr>
</tbody>
</table>
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 (see page 2) 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 coverage 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 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 (see page 2).
What is covered

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

Summary of benefits

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

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

<table>
<thead>
<tr>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayment</td>
<td>Payment allowance</td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

Routine vision care

One eye examination per member each calendar year

<table>
<thead>
<tr>
<th>Eye examination</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15</td>
<td>0%</td>
<td>$30</td>
</tr>
</tbody>
</table>

In order to receive in-network benefits, services should be received from a Blue View Vision Network provider. For out-of-network care, you will be responsible for the difference between the allowance and the provider’s charge.
What is not covered (Exclusions)

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

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

- vision services or supplies unless needed due to eye surgery and accidental injury;
- routine vision care, except as outlined on page 2 of this booklet;
- experimental/investigative vision procedures or materials, as well as services related to or complications from such procedures;
- services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics;
- sunglasses or safety glasses and accompanying frames of any type;
- any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power;
- any lost or broken lenses or frames;
- any blended lenses (no line), oversize lenses, polycarbonate lenses (for dependents over the age of 19 and adults), progressive multifocal lenses, photochromatic lenses, Transitions lenses (for dependents over the age of 19 and adults), tinted lenses, coated lenses, anti-reflective coating, cosmetic lenses or processes, or UV-protected lenses;
- 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; or
- any other vision services not specifically listed as covered.

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. The HMO 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 the HMO 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 the HMO 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 804-358-7390 in Richmond or 800-421-1880 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, 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 the HMO 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 12 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

The HMO 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;
6 - Claims and payments

- a facility or provider; or
- any other organization.

You will be required to cooperate with us to secure the HMO’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 the Evidence of coverage for your group's self funded health plan.

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 the HMO, 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 Inquiries, 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. The HMO 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
The HMO may adopt policies, procedures, rules, and interpretations to promote orderly and efficient administration of coverage under this EOC. Any provision, term, benefit, or condition of coverage and this EOC may be amended, revised, or deleted in accordance with the terms of the agreement between the HMO and the employer. This may be done without the member’s consent.

Complaint and appeal process
In order for us to remain responsive to your needs, we have established both a complaint process and an appeal process. Should you have a problem or question about the coverage provided under your vision care plan, a Member Services representative will assist you. Most problems and questions can be handled in this manner. You may also file a written complaint or appeal with us. Complaints typically involve issues such as dissatisfaction about our services, quality of care, the choice of and accessibility to our providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by us. 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:

Address:
HealthKeepers, Inc.
Attention: Member Services
P.O. Box 26623
Richmond, VA 23261-6623

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:

**Address:**
HealthKeepers, Inc.
Attention: Corporate Appeals Department
P.O. Box 26623
Richmond, VA 23261-6623

**Telephone:**
804-358-7390
in Richmond
800-421-1880
from outside Richmond

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

How 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 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 the HMO, 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:
804-527-4502
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.

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 the HMO 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 page 5). 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 the HMO 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 the HMO, 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.

The HMO’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.

The HMO’s relationship to providers
The choice of a vision care provider is solely the covered person’s. Providers are neither employees nor agents of the HMO. 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, the HMO’s right to direct future payments to a covered person or any other entity.

Once covered services are rendered by a provider, the HMO will not honor requests not to pay the claims submitted by the provider. The HMO 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.

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

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

**Covered persons**
are you and enrolled eligible dependents.

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

**Group administrator**
is the benefits administrator at your employer.

**HMO, we, us, our**
refers to HealthKeepers, Inc.

**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.

**You**
any member.
Your vision care plan
Blue View Vision care plan offered with health plan issued by HealthKeepers, Inc.
## Index

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeals</td>
<td>9</td>
</tr>
<tr>
<td>Canceling coverage (or ending coverage)</td>
<td>7</td>
</tr>
<tr>
<td>Changing coverage</td>
<td>7</td>
</tr>
<tr>
<td>Children (or dependents)</td>
<td>7</td>
</tr>
<tr>
<td>Claim filing</td>
<td>4</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>15</td>
</tr>
<tr>
<td>Eligibility for coverage</td>
<td>7</td>
</tr>
<tr>
<td>Exclusions</td>
<td>3</td>
</tr>
<tr>
<td>Filing a claim</td>
<td>4</td>
</tr>
<tr>
<td>Grievances (or appeals)</td>
<td>9</td>
</tr>
<tr>
<td>Network (or in-network and out-of-network)</td>
<td>1</td>
</tr>
<tr>
<td>Out-of-network</td>
<td>1</td>
</tr>
<tr>
<td>Phone numbers inside front cover</td>
<td></td>
</tr>
<tr>
<td>Spouses (or dependents)</td>
<td>7</td>
</tr>
<tr>
<td>Summary of benefits</td>
<td>2</td>
</tr>
</tbody>
</table>
Vision discount program

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

Your Eyewear Discounts

When you visit a Blue View Vision participating eye care professional or vision center, you’ll pay the discount price for as many pairs of eyeglasses and/or supplies of conventional (non-disposable) contact lenses as you would like. Discounts are subject to change without notice.

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Member Cost*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frame</td>
<td>35% off retail price</td>
</tr>
<tr>
<td>Standard Plastic Lenses</td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$50</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$70</td>
</tr>
<tr>
<td>Trilocal</td>
<td>$105</td>
</tr>
<tr>
<td>Lens Options</td>
<td></td>
</tr>
<tr>
<td>UV Coating</td>
<td>$15</td>
</tr>
<tr>
<td>Tint (Solid and Gradient)</td>
<td>$15</td>
</tr>
<tr>
<td>Standard Scratch-Resistance</td>
<td>$15</td>
</tr>
<tr>
<td>Standard Polycarbonate</td>
<td>$40</td>
</tr>
<tr>
<td>Standard Progressive (Add-on to bifocal)</td>
<td>$65</td>
</tr>
<tr>
<td>Standard Anti-Reflective Coating</td>
<td>$45</td>
</tr>
<tr>
<td>Other Add-ons and Services</td>
<td>20% off retail price</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td></td>
</tr>
<tr>
<td>Conventional (non-disposable) - materials</td>
<td>15% off retail</td>
</tr>
<tr>
<td>only</td>
<td></td>
</tr>
</tbody>
</table>

*Discounts apply towards a complete pair of eyeglasses. If eyeglass materials are purchased separately, a 20% discount is applied.

Plus, Anthem members have access to discounts on laser vision correction surgery and other vision discounts through SpecialOffers@Anthem.
HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. © ANTHEM and 360° Health are registered trademarks 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.