





A Division of Health Care Service Corporation, A Mutual Legal Reserve Company,  
an Independent Licensee of the Blue Cross and Blue Shield Association

300 E. Randolph Street Chicago, IL 60601

#### **NOTICE OF 10-DAY RIGHT TO EXAMINE POLICY**

Within ten days after its delivery to You, this Student Vision Policy may be surrendered by returning it to BCBSIL at Our administrative office, agent, or the entity through whom it was purchased. Upon such surrender, any Premiums paid will be returned. The Student is responsible for repaying Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (herein called "Blue Cross and Blue Shield of Illinois" and/or "BCBSIL") for any services rendered or Claims paid by BCBSIL on behalf of the Student and/or any Dependents during the ten-day examination period.

Notice: This Policy is subject to: (1) Annual Maximums, for other than Pediatric Services; (2) the right to adjust the Premium upon 60 days' notice to You. Such adjustments in rates shall become effective on the date specified in said notice; (3) termination of coverage in accordance with the *Termination of Coverage* section as specified in this Policy.

#### **Blue Cross and Blue Shield of Illinois**

(Herein called BCBSIL, We, Us, Our)

Has issued this

#### **Student Vision Policy**

to

#### **School of the Art Institute of Chicago**

This Policy becomes effective at 12:01 A.M., Standard Time, on the Effective Date of Coverage shown on the Identification Card and will be continued in effect by the payment of Premiums at the rates determined by Us in accordance with the provisions in the **Premiums and Reinstatement Provisions** section until terminated as provided in the **Termination of Coverage** section of this Policy.

This Policy is issued in the State of Illinois and is governed in accordance with the laws of this State.

Changes in state or federal law or regulations, or interpretation thereof, may change the terms and conditions of coverage.

Signed for Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company by:

Brian Snell, President  
Blue Cross and Blue Shield of Illinois

AcademicBlue is offered by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

A message from:

## BLUE CROSS AND BLUE SHIELD OF ILLINOIS

BCBSIL has contracted with EyeMed Vision Care, LLC (EyeMed), also referred to as the “network administrator.” EyeMed provides customer service and network administration services to Members enrolled in this BCBSIL Student Vision Policy. BCBSIL has also contracted with First American Administrators (FAA) to provide Claims administration services to Members enrolled in this BCBSIL Student Vision Policy. The relationship between BCBSIL, FAA, and EyeMed is that of independent contractors. Through our arrangement with EyeMed, You will have access to EyeMed’s Select network of Vision Care Providers.

Like most people, You probably have many questions about Your coverage. This Policy contains information about the services and supplies for which Benefits will be provided under Your Student Vision Policy. Please read Your entire Policy very carefully. We hope that most of the questions You have about Your coverage will be answered.

The **Definitions** section will explain the meaning of many of the terms used in this Policy. All terms used in this Policy, when defined in the **Definitions** section, begin with a capital letter. Whenever the term “We”, “Us”, or “Ours” is used, it means BCBSIL.

If You have any questions once You have read this Policy, call EyeMed at the number listed on Your Student Vision Identification Card. It is important to all of Us that You understand the protection this coverage gives You.

The Policyholder has confirmed to Us that it is an Institution of higher education as defined in the Higher Education Act of 1965 (the “Institution”). This Policy does not make vision insurance available other than in connection with enrollment as a Student (or a Dependent of a Student) in the Policyholder’s Institution. Policyholder will provide prospective and current Covered Persons with access to this Policy.

**Notice:** This Student Vision Policy is subject to the right to adjust the Premium upon 60 days’ notice to You. Such adjustments in rates shall become effective on the date specified in said notice.

Welcome to the BCBSIL Student Vision Plan! We are very happy to have You and pledge You Our best service.

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# Schedule of Benefits

## AcademicBlue<sup>SM</sup> Vision Plan 1B

| Vision Care Benefits                                                                                                                                 | EyeMed Provider                                            | Non-Contracting Provider Reimbursement* |
|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------|
| Exam with Dilation as Necessary                                                                                                                      | \$10 Copay                                                 | Up to \$30                              |
| <b>Frames:</b><br>Any available frame at Provider location                                                                                           | \$0 Copay, \$130 Allowance, 20% off balance over \$130     | Up to \$65                              |
| <b>Contact Lens Fit and Follow-Up</b><br>(Contact Lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.) |                                                            |                                         |
| Standard Contact Lens Fit and Follow-Up                                                                                                              | \$0 Copay, Paid-in-Full, and two follow-up visits          | Up to \$40                              |
| Premium Contact Lens Fit and Follow-Up                                                                                                               | \$0 Copay, 10% off Retail Price, then apply \$40 Allowance | Up to \$40                              |
| <b>Standard Plastic Lenses:</b>                                                                                                                      |                                                            |                                         |
| Single Vision                                                                                                                                        | \$20 Copay                                                 | Up to \$8                               |
| Bifocal                                                                                                                                              | \$20 Copay                                                 | Up to \$18                              |
| Trifocal                                                                                                                                             | \$20 Copay                                                 | Up to \$35                              |
| Lenticular                                                                                                                                           | \$20 Copay                                                 | Up to \$35                              |
| Standard Progressive Lens                                                                                                                            | \$0 Copay                                                  | Up to \$60                              |
| Premium Progressive Lens as follows: **                                                                                                              |                                                            |                                         |
| Premium Progressive Lens -Tier 1                                                                                                                     | \$85 Copay                                                 | Up to \$60                              |
| Premium Progressive Lens -Tier 2                                                                                                                     | \$95 Copay                                                 | Up to \$60                              |
| Premium Progressive Lens -Tier 3                                                                                                                     | \$110 Copay                                                | Up to \$60                              |
| Premium Progressive Lens -Tier 4                                                                                                                     | \$85 Copay, 20% off Retail less \$120 Allowance            | Up to \$60                              |
| <b>Lens Options:</b>                                                                                                                                 |                                                            |                                         |
| Standard Plastic Scratch Coating                                                                                                                     | \$15 Copay                                                 | Up to \$8                               |
| Standard Polycarbonate - Kids under 19                                                                                                               | \$0 Copay                                                  | Up to \$20                              |
| <b>Contact Lenses:</b><br>(Contact Lens allowance includes materials only.)                                                                          |                                                            |                                         |
| Conventional                                                                                                                                         | \$0 Copay, \$130 Allowance, 15% off balance over \$130     | Up to \$104                             |

|                     |                                                     |             |
|---------------------|-----------------------------------------------------|-------------|
| Disposable          | \$0 Copay, \$130 Allowance, plus balance Over \$130 | Up to \$104 |
| Medically Necessary | \$0 Copay, Paid-in-Full                             | Up to \$210 |

| <b>Vision Care Services**</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>Member Cost</b>                                                                                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Retinal Imaging Benefit                                                                                                                                                                                                                                                                                                                                                                                                                                        | Up to \$39                                                                                                                                                                 |
| <b>Lens Options</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                            |
| UV Treatment                                                                                                                                                                                                                                                                                                                                                                                                                                                   | \$15 Copay                                                                                                                                                                 |
| Tint (Solid and Gradient)                                                                                                                                                                                                                                                                                                                                                                                                                                      | \$15 Copay                                                                                                                                                                 |
| Standard Polycarbonate - Adults                                                                                                                                                                                                                                                                                                                                                                                                                                | \$40 Copay                                                                                                                                                                 |
| Standard Anti-Reflective Coating                                                                                                                                                                                                                                                                                                                                                                                                                               | \$45 Copay                                                                                                                                                                 |
| Premium Anti-Reflective Coating – <i>Tier 1</i>                                                                                                                                                                                                                                                                                                                                                                                                                | \$57 Copay                                                                                                                                                                 |
| Premium Anti-Reflective Coating – <i>Tier 2</i>                                                                                                                                                                                                                                                                                                                                                                                                                | \$68 Copay                                                                                                                                                                 |
| Premium Anti-Reflective Coating – <i>Tier 3</i>                                                                                                                                                                                                                                                                                                                                                                                                                | 20% off Retail Price                                                                                                                                                       |
| Polarized                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 20% off Retail Price                                                                                                                                                       |
| Photochromic (Plastic)                                                                                                                                                                                                                                                                                                                                                                                                                                         | 20% off Retail Price                                                                                                                                                       |
| Other Add-Ons                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20% off Retail Price                                                                                                                                                       |
| <b>Laser Vision Correction</b><br>Lasik or PRK from U.S. Laser Network                                                                                                                                                                                                                                                                                                                                                                                         | 15% off Retail Price or 5% off promotional price                                                                                                                           |
| <b>Additional Pairs Benefit:</b>                                                                                                                                                                                                                                                                                                                                                                                                                               | Covered Persons also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded Benefit has been used. |
| <b>Frequency:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                            |
| Examination                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Once every 12 months                                                                                                                                                       |
| Lenses or Contact Lenses                                                                                                                                                                                                                                                                                                                                                                                                                                       | Once every 12 months                                                                                                                                                       |
| Frame                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Once every 12 months                                                                                                                                                       |
| Premium is subject to adjustment even during a rate guarantee period in the event of any of the following events: change in Benefits or the imposition of any new taxes, fees, or assessments by Federal or State regulatory agencies.                                                                                                                                                                                                                         |                                                                                                                                                                            |
| *Reimbursement for Non-Contracting Provider Vision Services and Materials will be the lesser of the listed amount or the actual cost from the Non-Contracting Provider. In certain states, Covered Persons may be required to pay the full retail price, and not the negotiated discount rate with certain participating Providers. Please see EyeMed's online Provider locator to determine which participating Providers have agreed to the discounted rate. |                                                                                                                                                                            |
| **No insurance Benefit is provided, EyeMed Provider or Non-Contracting Provider. Member cost displayed is a negotiated and agreed-upon discount with Contracted Providers. For Non-Contracting Providers, Member will pay charged amount.                                                                                                                                                                                                                      |                                                                                                                                                                            |
| EyeMed Vision Care reserves the right to make changes to the products on each tier and the out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All Providers are not required to carry all brands at all levels.                                                                                                                                                                                                           |                                                                                                                                                                            |

**Required Notice:** READ YOUR PLAN CAREFULLY – THIS BENEFITS SCHEDULE PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE POLICY. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU UPON YOUR REQUEST TO US.

## **THINGS YOU SHOULD KNOW**

This Policy describes the Benefits available to Students and their Dependents under this Student Vision Policy. If after reading it, You still have questions, please contact EyeMed Customer Service for BCBSIL Student Vision Policy Members.

### **SCHEDULE OF BENEFITS**

A Schedule of Benefits is included in this Policy showing You what You will pay, or be reimbursed, for a Covered Service. Covered Persons will receive a new Schedule of Benefits if changes are made to this Student Vision Policy.

### **CUSTOMER SERVICE**

Questions about services covered under this Student Vision Policy, EyeMed Contracting Providers, or about Benefits provided for or denied under this Student Vision Policy can be directed to EyeMed seven days a week.

**EyeMed**  
**Hours: Central Time**  
**Monday through Saturday 6:30 A.M. to 10:00 P.M.**  
**1-888-782-3299**

An Interactive Voice Response unit is also available outside normal business operating hours. (Please direct Student enrollment, termination, and other Student or Dependent eligibility questions to Your Institution - not to EyeMed.)

Covered Persons who use a TTY (Teletypewriter) because of a hearing or speech disability may access TTY services by calling or using a TTY machine to engage an operator at 711 and asking the operator to call EyeMed at 1-844-230-6498.

If a Claim for Benefits is denied (in whole or in part), FAA will notify You in writing of the specific reasons for the denial, and of the process for requesting a review of the denial.



## ELIGIBILITY FOR INSURANCE

Each person in one of the Class(es) of eligible persons shown below is eligible to be covered under this Policy. This includes anyone who is eligible on the Effective Date of Coverage and may become eligible after the Effective Date of Coverage while the Policy is in force. Students must meet the Institution's requirements for maintaining their status as an eligible Student. Students must maintain their eligibility in order to maintain or continue coverage under this policy. Students enrolled for the Summer sessions will not experience a loss in coverage as long as they were covered immediately preceding Summer sessions. (These Students may be eligible for continuation coverage as provided for in the policy for 6 months.) We maintain the right to investigate Student status and attendance records to verify that eligibility requirements have been met. If We discover the eligibility requirements have not been met, Our only obligation is to refund any unearned Premium paid for that person.

### CLASSES OF ELIGIBLE PERSONS

Class 1: All Students and their Dependents are eligible for coverage under this Policy.

NOTE: Multiple classes may be added depending on the Institution.

A person may not be insured as a Dependent and a Student at the same time.

A Student's Dependent is eligible on the date:

- The Student is eligible if the Student has Dependents on that date; or
- The date the person becomes a Dependent of the Student, if later.

**No eligibility rules or variations in Premium will be imposed based on a Student's health status, medical condition, claims experience, receipt of health care, medical or vision history, genetic information, evidence of insurability, disability, or any other health status factor. A Student will not be discriminated against for coverage under this Policy on the basis of race, color, national origin, disability, quality of life, life expectancy, age, sex, gender identity, sexual orientation, or political affiliation. Coverage does not require documentation certifying a COVID-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving Benefits. Variations in the administration, processes or Benefits of this Policy that are based on clinically indicated, reasonable management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.**



## EFFECTIVE DATE OF COVERAGE

Coverage for a Student who enrolls during the Institution's enrollment period, as determined by the Institution, is effective on the latest of the following dates:

- The Effective Date of Coverage;
- The date We receive the completed online enrollment form;
- The date after the required Premium is paid; or
- The date the Student enters the eligible class.

Coverage for a Student's eligible Dependent who enrolls: (1) during the enrollment period established by the Institution; (2) within 31 days after the Student acquires a new Dependent; or (3) within 31 days after a Dependent terminates coverage under another vision plan, is effective on the latest of the following dates:

- The Effective Date of Coverage;
- The date the Student enters the eligible class; or
- The date after the required Premium is paid.

After the time periods described above, the Student and/or Dependent must wait until the next enrollment period, except for a newborn or newly adopted child or if there is an involuntary loss of coverage under another vision plan.

We will pay Benefits for a newborn child of a Covered Person until that child is 31 days old. Coverage may be continued beyond the 31 days if the Covered Person notifies Us of the child's birth and pays the required Premium, if any.

Adopted children, as defined by this Policy, will be covered on the same basis as a newborn child from the date the child is placed for adoption with the Covered Person or the date the Covered Person becomes a party to a suit for the adoption of the child. Coverage will cease on the date the child is removed from placement and the Covered Person's legal obligation terminates.

## OPEN ENROLLMENT PERIODS

Your Institution will designate Open Enrollment Periods during which You may apply for or change Your coverage under this Student Vision Policy.

## QUALIFYING EVENT

Eligible Students and/or Eligible Dependents who have a change in status, and lose coverage under another vision plan, are eligible to enroll for coverage under this Policy. Within 30 days of the qualifying event, the Student and/or Dependent must complete supporting documentation. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, including Domestic Partner, whether by death, divorce or annulment, a gain of a Dependent whether by birth, adoption, or suit for adoption or court-ordered Dependent coverage, or loss of Dependent status because of age. The Premium will be the same as what it would have been at the beginning of the semester or quarter, whichever applies. However, the Effective Date of Coverage will be the later of the date the Student or Dependent enrolls for coverage under this Policy and pays the required Premium, or the day after the prior coverage ends. Please contact Your Institution for further information.

# HOW THE VISION CARE PLAN WORKS

## VISION EXAMINATION

Under this Student Vision Policy, You may visit any Provider and receive Benefits (as listed on the Schedule of Benefits) for a Vision Examination and Vision Materials.

A Vision Examination is a vision testing exam that includes a determination as to the need for correction of visual acuity and prescribing lenses, if needed, that is performed by a licensed physician, optometrist, therapeutic optometrist, or ophthalmologist who is operating within the scope of his or her license. A comprehensive routine eye examination (including dilation, if necessary) includes but is not limited to the following procedures:

- Case history, including chief complaint and/or reason for visit, patient medical and eye health history, and record of current medications;
- Record of visual acuities with or without present correction, if applicable;
- Pupil responses, external exam findings, internal exam findings, screening of visual fields perception;
- Present prescription;
- Retinoscopy (when applicable), subjective refraction at far and near point;
- Binocular and ocular mobility testing;
- Test of accommodation and/or near point refraction;
- Tonometry, to include pressures, time of day, and type of instrument used (a reasonable attempt at tonometry or equivalent testing will be made unless, in the physician's professional opinion, tonometry is contraindicated); and
- Diagnosis/prognosis and/or specific recommendations.

## EyeMed CONTRACTING PROVIDER

Before You go to an EyeMed Contracting Provider for a Vision Examination or Vision Materials, please call ahead for an appointment. When You arrive, present Your Student Vision Policy Identification Card. If You forget to take Your card, be sure to say that You are a Member of the BCBSIL Student Vision Plan so that Your eligibility can be verified.

Visit EyeMed's website at [www.eyemedvisioncare.com/bcbsilind.com](http://www.eyemedvisioncare.com/bcbsilind.com) or call 1-888-782-3299 to obtain a list of the EyeMed Contracting Providers nearest You.

You may receive Your Vision Examination and eyeglasses or contacts on different dates or through different Provider locations, if desired.

Fees charged for service other than a covered Vision Examination, covered Vision Materials, or discounted Vision Materials and amounts in excess of those payable under this Student Vision Policy, must be paid in full by You to the Provider, whether or not the Provider is an EyeMed Contracting Provider. Benefits under this Student Vision Policy may not be combined with any promotional offering. Allowances are one-time use Benefits; no remaining balances are carried over to be used later.

## **LIMITATIONS AND EXCLUSIONS**

This Student Vision Policy does not cover services or materials connected with or charges arising from:

- any vision service, treatment or materials not specifically listed as a Covered Service;
- services or materials which are rendered prior to Your Effective Date of Coverage;
- services and materials incurred after the termination date of Your coverage unless otherwise indicated;
- more than one examination in each successive 12-month Benefit Period;
- services and materials not meeting accepted standards of optometric practice;
- services and materials resulting from Your failure to comply with professionally prescribed treatment;
- telephone consultations;
- any charges for failure to keep a scheduled appointment;
- any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- any eye or Vision Examination, or any corrective eye wear required by an employer as a condition of employment, and safety eyewear;
- services or materials provided as a result of intentionally self-inflicted injury or illness;
- services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- office infection control charges;
- charges for copies of Your records, charts, or any costs associated with forwarding/mailling copies of Your records or charts;
- state or territorial taxes on vision services performed;
- medical treatment of eye disease or injury;
- visual therapy;
- special lens designs or coatings other than those described in this Student Vision Policy;
- replacement of lost/stolen eyewear;
- non-prescription (Plano) lenses;
- two pairs of eyeglasses in lieu of bifocals;
- services not performed by licensed personnel;
- prosthetic devices and services; and
- insurance of contact lenses.

Please contact Customer Service if You have any questions.

# **TERMINATION OF COVERAGE**

## **TERMINATION DATE OF INSURANCE**

A Student's coverage will end on the earliest of the date:

- This Policy terminates;
- The Student is no longer eligible; or
- The period ends for which Premium is paid.

A Dependent's coverage will end on the earliest of the date:

- He or she is no longer a Dependent;
- The Student's coverage ends; or
- The period ends for which Premium is paid; or
- The Policy terminates.

We may terminate this Policy by giving 31 days written (authorized electronic or telephonic) notice to the Institution. Either We or the Institution may terminate this Policy on any Premium due date by giving 31 days advance written (authorized electronic or telephonic) notice to the other. This Policy may be terminated at any time by mutual written or authorized electronic/telephonic consent of the Institution and Us.

This Policy terminates automatically on the earlier of:

- The Policy Termination Date shown in the Policy;
- The Premium due date if Premiums are not paid when due; or
- The Policy effective date of the renewal of this Policy if a Student decides to renew coverage under this Student Vision Policy, and the Policy effective date of the renewal of this Student Vision Policy becomes effective before this Policy terminates.

Termination takes effect at 12:00 AM, Standard Time at the address of the Institution on the date of termination.

## **REFUND OF PREMIUM**

A refund of Premium will be made only in the event:

- Of a Covered Person's death; or
- The Covered Person enters full-time active duty in any Armed Forces, and We receive proof of such active-duty service.

## **EXTENSION OF BENEFITS**

If a Covered Person's coverage under this Policy terminates, Benefits will continue for any Covered Vision Services described in this Policy, as long as the Covered Service began prior to the date the coverage terminated and is completed within 30 days of a Covered Person's termination date. NOTE: If a Covered Person terminates coverage under this Policy, they will not be eligible to re-enroll for vision coverage until the next annual Open Enrollment Period if applicable.

## **CONTINUATION OF COVERAGE**

A Covered Person who has been insured under the Policy may continue to be insured under the Policy when coverage terminates subject to the following:

- Continuation of Coverage is available to all Students and their covered Dependents, when the Student leaves school, dies, or when the covered Dependent no longer qualifies as an eligible Dependent.

- The Covered Person requesting coverage must have been insured under this Policy for at least 3 months.
- Requests for Continuation of Coverage, with the applicable Premium, must be submitted within 30 days of:
  - The date the existing coverage would otherwise terminate; or
  - The date the Covered Person is notified of the right to continue the coverage.
- Coverage and Benefits will be the same as those which are applicable prior to continuation.
- Premium rates for Continuation of Coverage may be higher than Student rates.
- The maximum period for which coverage may be continued is 6 months.

Continuation of Coverage is not available to persons who are eligible for coverage under another vision care plan, including Medicare.

# PROCEDURES FOR FILING CLAIMS, APPEALS, AND COMPLAINTS

## EyeMed CONTRACTING PROVIDER SERVICES

When You receive Vision Services at an EyeMed Contracting Provider location, You will not have to file a Claim form. At the time services are rendered, You will pay for the services or eyewear at the amount noted on Your Schedule of Benefits. You will also owe state tax, if applicable and the cost of noncovered expenses (for example, vision perception training).

## CLAIM FORMS AND PROOF OF LOSS

Written Proof of Loss must be furnished to FAA in accordance with the Claim procedures specified in this section. Proof may be submitted either electronically or on paper. Written notice of Claim must be given to FAA within 90 days after the occurrence or start of the loss on which the Claim is based. If notice is not given in that time, the Claim will not be invalidated or denied if it is shown that written notice was given as soon as was reasonably possible. When FAA receives a request for a Claim form or the notice of a Claim, FAA will provide the Covered Person the Claim forms that are used for filing Proof of Loss. If the Covered Person does not receive these forms within 15 days after FAA receives notice of Claim or the request for a Claim form, the Covered Person will be considered to have met the Proof of Loss requirement of this Student Vision Policy if the Covered Person submits written Proof of Loss within 365 days after the date of the first service, except in the absence of legal capacity.

## CLAIMS FOR NON-CONTRACTING PROVIDER VISION SERVICES

When You receive a Vision Examination or purchase Vision Materials from a Non-Contracting Provider, You may need to file a Claim form. You can obtain a Claim form from an EyeMed Member Services Representative or at [www.eyemed.com](http://www.eyemed.com). Be sure to fill out the Claim form completely. You must submit Your Claim form no more than 15 months after the services were provided. If You choose to go to a Non-Contracting Provider, please complete the following steps before submitting Your Claim form to FAA.

1. You are responsible for payment of Vision Services at the time of service. BCBSIL (through the claims administrator, FAA) will reimburse You for Covered Services. Please see the Schedule of Benefits for the list of qualified service and their reimbursement amounts.
2. Complete the Claim form in its entirety. Sign the Claim form. If the patient is a minor, the parent or legal guardian must sign the Claim form.
3. Attach itemized receipts from Your Provider to the Claim form. (Facsimiles and photocopies of bills cannot be accepted; please keep copies for Your records. Bills will not be returned.)

Mail the Claim form to the following address:

**BlueCare Vision  
c/o First American Administrators  
Attn: OON Claims  
P.O. Box 8504  
Mason, OH 45040-7111**

## PAYMENT IN ERROR

If BCBSIL makes an erroneous Benefit payment, You or the ineligible person may be required to refund the amount paid in error. BCBSIL reserves the right to correct payments made in error by offsetting the amount paid in error against new Claims. BCBSIL also reserves the right to take legal action to collect payments made in error.

## COMPLAINT PROCEDURE

If You are dissatisfied with an EyeMed Provider's quality of care, Vision Services, Materials or facility or with FAA's claims administration, You should first call EyeMed Customer Care Center at 1-800-239-4176 to request resolution. The EyeMed Customer Care Center will make every effort to resolve Your matter informally.

If You are not satisfied with the resolution from the Customer Care Center service representative, You may file a formal Complaint with BCBSIL at the address noted below. You may also include written comments or supporting documentation.

BCBSIL will resolve Your Complaint within thirty (30) days after receipt unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after BCBSIL receipt of Your Complaint. Upon final resolution, BCBSIL will notify You in writing of its decision.

You may also submit your Complaint and general inquires to the Illinois Department of Insurance using the following contact information:

**Illinois Department of Insurance  
Office Consumer Health Insurance  
320 West Washington Street  
Springfield, IL 62767  
(877) 527-9431  
(217) 558-2083 Fax number  
complaints@ins.state.il.us Email address  
<https://mc.insurance.illinois.gov/messagecenter.nsf>**

### **APPEALING DENIED CLAIMS**

If Your Claim is denied, in whole or in part, You may file an Appeal. The Appeal must be in writing and received by BCBSIL, within 180 days of Your notice of the denial. If You do not receive an explanation of Benefits (EOB) within 30 days of submission of Your Claim, You may submit an Appeal within 180 days after this 30-day period has expired. Your written letter of Appeal should include the following:

- the applicable Claim number, or a copy of the denial information, or a copy of the EOB, if applicable;
- the item of vision coverage that You think was misinterpreted or inaccurately applied;
- additional information from Your Vision Care Provider that will assist BCBSIL in completing its review of Your Appeal, such as documents, records, questions or comment.

The written letter of Appeal should be mailed or faxed to the following address:

**Blue Cross and Blue Shield of Illinois  
P.O. Box 3122  
Naperville, IL 60566-9744  
1-800-538-8833  
1-866-414-4258 Fax number**

**Send a secure email by using our message center by logging into  
Blue Access for Members<sup>SM</sup> (BAM) at [www.bcbsil.com](http://www.bcbsil.com)**



## **GENERAL PROVISIONS**

### **CLAIM FORMS**

We will furnish to You, Your Physician or Vision Care Provider, upon receipt of a notice of Claim or prior thereto, such forms as We usually furnish for filing Proof of Loss. If such forms are not furnished within 15 days after receipt of such notice by Us, the Covered Person shall be deemed to have complied with the requirements of this Policy as to Proof of Loss upon submitting, within the time fixed in the Policy for filing such Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which Claim is made.

### **DISCLOSURE AUTHORIZATION**

The Covered Person, on behalf of himself and his Dependents, shall be deemed to have authorized any attending Physician or Vision Care Provider to furnish Us all information and records or copies of records relating to the diagnosis, treatment, or care of any Covered Person included under this Student Vision Policy; and such Covered Persons shall, by asserting claim for Benefits hereunder, be deemed to have waived all provisions of law forbidding the disclosure of such information and records.

As a condition to the continued coverage of a child as a disabled Dependent beyond the age of 26, We shall have the right to require periodic certification of the child's physical or mental condition and dependency, but not more frequently than annually after the two-year period following the child's attainment of age 26.

### **GENDER**

Use herein of a personal pronoun in the masculine gender shall be deemed to include the feminine unless the context clearly indicates the contrary.

### **LEGAL ACTION**

No action at law or in equity shall be brought to recover on this Student Vision Policy prior to the expiration of 60 days after written Proof of Loss has been filed in accordance with requirements herein and no such action shall be brought at all unless brought within three years from the expiration of the time within which written Proof of Loss is required to be furnished under this Student Vision Policy.

### **INFORMATION AND RECORDS**

You agree that it is Your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for Benefits are made under this Student Vision Policy, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnification on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to this Student Vision Policy or its agent, and agrees that any such Provider, person, or other entity may furnish to this Student Vision Policy or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, this Student Vision Policy may furnish similar information and records (or copies of records) to Providers, other Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs, or other entities providing insurance-type benefits requesting the same.

### **NON-AGENCY**

The Institution understands that this Vision Plan constitutes a Policy solely between the Institution and BCBSIL. BCBSIL is a Division of Health Care Service Corporation, an Independent Licensee of the Blue Cross and Blue Shield Association (the Association). The license from the Association permits HCSC to use the Blue Cross and Blue Shield Service Marks in the State of Illinois. BCBSIL is not contracting as the agent of the Association. The Institution also understands that he has not entered into this Student Vision Policy based upon representations by a person other than BCBSIL. No person, entity, or organization other than BCBSIL shall be held accountable or liable to the Institution for any of its obligations whatsoever on the on the part of BCBSIL other than those obligations created under other provision of this Student Vision Policy.

## **NOTICES**

Any information or notice which You furnish to BCBSIL under this Student Vision Policy must be in writing and sent to the BCBSIL at its offices at 300 East Randolph Street, Chicago, Illinois, 60601-5099 (unless another address has been stated in this Student Vision Policy for a specific situation). Any information or notice which this Student Vision Policy furnishes to You must be in writing and sent to You at Your address as it appears on the Student Vision Policy's records or, if applicable, in the case of a medical child support order, to the designated representative as it appears on this Student Vision Policy's records. Blue Cross and Blue Shield may also provide such notices electronically, to the extent permitted by applicable law.

## **NOTICE OF CLAIM**

The Covered Person shall give or cause to be given written notice to FAA within 30 days or as soon as reasonably possible after any Covered Person receives any of the services for which Benefits are provided herein.

## **PHYSICAL EXAMINATION AND AUTOPSY**

We, at Our own expense, shall have the right and opportunity to examine the person of the Student for whom Claim is made, when and so often as We may reasonably require during the pendency of a Claim hereunder and also in case of death, the right and opportunity to make an autopsy where it is not prohibited by law.

## **ENTIRE CONTRACT; CHANGES**

This Policy and the application for coverage by the Student and any amendments, riders, or endorsements attached hereto, shall constitute the entire Student Vision Policy. Any statements made shall be deemed representations and not warranties, and no statement made by the Student in the application for this Student Vision Policy shall be used in any contest or in defense of a Claim hereunder unless a copy of the application is attached to this Student Vision Policy when issued.

Only an authorized officer of BCBSIL has the power to change, modify, or waive the provisions of this Policy, and then only in writing prepared at the home office and attached or endorsed hereto. We shall not be bound by any promise or representation heretofore or hereafter made by or to any agent other than as specified above.

## **PROOF OF LOSS**

Written Proof of Loss must be furnished to FAA, no later than 90 days from the date that the services, supplies or appliances are provided to the Covered Person. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and, in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

## **REFUND OF BENEFIT PAYMENTS**

If and when We determine that Benefit payments hereunder have been made erroneously but in good faith, We reserve the right to seek recovery of such Benefit payments from the Covered Person, any other insurance company, or Provider of services to whom such payments were made. We reserve the right to offset subsequent Benefit payments otherwise payable by the amount of any such overpayment.

## **REIMBURSEMENT**

If We pay or provide Benefits for You under this Policy, We are subrogated to all rights of recovery which You have in contract, tort or otherwise against any person, organization or insurer for the amount of Benefits We have paid or provided. That means We may use the Institution's rights to recover money through judgment, settlement or otherwise from any person, organization or insurer.

1. For the purposes of this provision, Subrogation means the substitution of one person or entity (BCBSIL) in the place of another (any Student covered under this Student Vision Policy) with reference to a lawful Claim, demand, or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or Claim, and its rights or remedies.

2. **Right of Reimbursement:** In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, We will have a right for reimbursement. If any Student covered under this Student Vision Policy recovers money from any person, organization or insurer for an injury or condition for which We paid Benefits under this Student Vision Policy, all Students covered under this Student Vision Policy agrees to reimburse Us from the recovered money for the amount of Benefits paid or provided by Us. That means any Student covered under this Student Vision Policy will pay Us the amount of money recovered through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organizations or insurer, up to the amount of Benefits We paid or provided.
3. **Right to Recovery by Subrogation or Reimbursement:** Any Student covered under this Student Vision Policy agrees to promptly furnish to Us all information concerning any Student's rights of recovery from any person, organization or insurer and to fully assist and cooperate with Us in protecting and obtaining its reimbursement and subrogation rights. Any Student covered under this Student Vision Policy, or their attorney will notify Us before settling any Claim or suit so as to enable Us to enforce Our rights by participating in the settlement of the Claim or suit. Any Student covered under this Student Vision Policy further agrees not to allow the reimbursement and subrogation rights BCBSIL to be limited or harmed by any acts or failure to act on the part of any Student.
4. Notwithstanding the foregoing, nothing herein shall be interpreted to allow recovery from a Student's coverage under Medicare, Medicare Advantage or Medicaid benefit plan.

## **RECISSION OF COVERAGE**

We may not void coverage based on a misrepresentation by a Student unless the Student performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact with the intent to deceive this Student Vision Policy on the Student's application; having done so will result in the cancellation of coverage for the Student retroactive to the Effective Date of Coverage, subject to 30 days' prior notification. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. In the event of such cancellation, Blue Cross and Blue Shield of Illinois may deduct from the Premium refund any amounts made in Claim Payments during this period and the Student may be liable for any Claim Payment amount greater than the total amount of Premiums paid during the period for which cancellation is affected.

## **CONFORMITY WITH STATE STATUTES**

Any provision of this Policy which, on its Effective Date of Coverage, is in conflict with the statutes of the state in which it was delivered shall be amended to conform with the minimum requirements of those statutes.

## **PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS**

BCBSIL has contracts with certain Providers ("Plan Providers") in its service area to provide and pay for Vision Services to all person entitled to vision care Benefits under vision policies and contracts to which BCBSIL is a party, including all persons covered under this Student Vision Policy. Under certain circumstances described in its contract with Plan Providers, BCBSIL may:

- receive substantial payments from Providers or suppliers with respect to goods, supplies and services furnished to all such persons for which BCBSIL was obligated to pay the Provider or supplier; or
- pay Providers or suppliers substantially less than their Claim charges for goods and services, by discount or otherwise; or
- receive from Providers or supplier's other substantial allowances under the BCBSIL contracts with them.

## **SEVERABILITY**

In case any one or more of the provisions contained in this Policy shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of this Student Vision Policy, but this Policy shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

## **TIME FOR PAYMENT OF CLAIMS**

Claims payable under this Student Vision Policy for any loss other than loss for which this Student Vision Policy provides any periodic payment will be paid immediately upon receipt of due written Proof of Loss. Subject to due written Proof of Loss, all accrued Claims for loss for which this Student Vision Policy provides periodic payment will be paid not less frequently than monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written Proof of Loss. Claims shall be paid within 30 days following receipt of written due Proof of Loss. Failure to pay within such period shall entitle the Covered Person to interest at the rate of 9% per annum from the 30th day.

## **PREMIUMS AND REINSTATEMENT PROVISIONS**

### **PAYMENT OF PREMIUM**

On or before the Premium due date, You must remit the required Premium to Your Institution.

Only if Your Institution receives Your stipulated payment, will You be entitled to Vision Services covered hereunder. If any required payment is not received by the Premium due date, or if there is a bank draft failure, then You will be terminated at the end of the grace period. You will be responsible for the cost of services rendered to You during the grace period.

Your Institution reserves the right to change the schedule of Premium payments on each anniversary date of this Student Vision Policy upon sixty (60) days written notice.

### **GRACE PERIOD**

Unless not less than 31 days prior to the premium due date, BCBSIL has delivered to the Student or has mailed to the Student's last address as shown on the records of BCBSIL written notice of its intention not to renew this Policy beyond the period for which the premiums have been accepted, a grace period of ten days will be granted for the payment of each monthly premium amount falling due after the first premium payment, during which grace period the Policy will continue in force.

### **REINSTATEMENT**

If this Policy terminates due to default in Premium payment(s), the subsequent acceptance of such defaulted Premium by Us or any duly authorized agents shall fully reinstate the Policy. For purposes of this section mere receipt and/or negotiation of a late Premium payment does not constitute acceptance. Any Reinstatement of the Policy shall not be deemed a waiver of either the requirement of timely Premium payment or the right of termination for default in Premium payment in the event of any future failure to make timely Premium payments.

# **PAYMENT OF BENEFITS; PROVIDER RELATIONSHIP**

## **PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS**

All Benefit payments may be made by BCBSIL directly to any Provider furnishing the Covered Services for which such payment is due, and BCBSIL is authorized by You to make such payments directly to such Providers. However, BCBSIL may pay any Benefits that are payable under the terms of this Student Vision Policy directly to You, unless reasonable evidence of a properly executed and enforceable assignment of Benefits has been received by this Student Vision Policy sufficiently in advance of BCBSIL's Benefit payment. You may be required to submit a copy of the assignment of Benefit's to BCBSIL.

1. Once Covered Services are rendered by a Provider, You have no right to request the Plan not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, BCBSIL will have no liability to You or any other person because of its rejection of such request.
2. Except for the assignment of a Benefit payment described above, a Covered Person's Claim for Benefits under this Student Vision Policy is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a Covered Person. Coverage under this Student Vision Policy is expressly non-assignable and non-transferable and will be forfeited if You attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a Claim for Benefits or coverage shall be null and void.

## **PROVIDER RELATIONSHIP**

The choice of a Provider is solely Your choice and BCBSIL will not interfere with Your relationship with any Provider. BCBSIL does not itself undertake to furnish Vision Services, but solely to make payments to Providers for Covered Services received by You. BCBSIL is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including but not limited to, the failure or refusal to render services to You. Professional services which can only be legally performed by a Provider are not provided by BCBSIL. The use of an adjective such as BCBSIL or Participating in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider.

## **TRANSFER OF BENEFITS**

All Benefits described in this Policy are personal to You. Neither these Benefits nor BCBSIL payments may be transferred or given to any person, corporation, or entity. Any attempted transfer will be void. Use of Benefits by anyone other than a Covered Person will be considered fraud or intentional misrepresentation in the use of services or facilities, which may result in cancellation of coverage for the Covered Person and appropriate legal action by BCBSIL.

## **VALUE BASED DESIGN PROGRAMS**

BCBSIL has the right to offer medical management programs, quality improvement programs, and health behavior wellness, maintenance, or improvement programs that allow for a reward, a contribution, a penalty, a differential in premiums, a differential in medical, prescription drug or equipment Copayments, Coinsurance, Deductibles or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by BCBSIL or an entity chosen by BCBSIL to administer such program. In addition, discount programs for various health or wellness-related, insurance-related or other items and services may be available from time to time. Such programs may be discontinued with or without notice.

Individuals unable to participate in these incentives due to an adverse health factor shall not be penalized based upon an adverse health status and, unless otherwise permitted by law, Blue Cross and Blue Shield will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

## DEFINITIONS

This section defines certain words used in this Student Vision Policy.

**Appeal** means a request for review of a denied or partially denied Claim and/or services.

**Benefit** means the payment and reimbursement of any kind which You will receive under this Student Vision Policy.

**Benefit Period** means the period of time in which a Benefit is payable.

**Civil Union** means a legal relationship between two persons of either the same or opposite sex, established pursuant to or as otherwise recognized by the Illinois Religious Freedom Protection and Civil Union Act. A party to a Civil Union shall be included in any definition or use of terms descriptive of spousal relationships and Dependents.

**Claim** means a formal statement or Claim regarding a loss which provides sufficient information to allow BCBSIL to determine its liability for Covered Services. This includes a completed Claim form, the Provider's itemized statement of services rendered, and related charges.

**Complaint** means any communication from the Covered Person or on the Covered Person's behalf which expresses:

- dissatisfaction;
- disagreement;
- lack of action; or
- threats.

**Copayment** means the designated amount, if any, shown in the Schedule of Benefits each Covered Person must pay to a Provider before Benefits are payable for Covered Services or Materials per Benefit Period.

**Covered Person** means a Student and/or Dependent who has applied for coverage and whose Premium due has been accepted.

**Covered Service** means a Vision Service or Vision Materials shown on the Schedule of Benefits and given by a Provider for which Benefits will be provided.

**Dependent** means:

- a Student's lawful spouse including Domestic Partner; or
- a Student's partner in a Civil Union (the term "spouse" includes a partner in a Civil Union); or
- a Student's child(ren).

"Child(ren)" used hereafter in the Policy means a natural child, a stepchild, foster child, adopted child, a child of a Student's Domestic Partner, a child who is in a Student's custody under an interim court order prior to finalization of adoption or placement of adoption vesting temporary care, whichever comes first, a child of a Student's child, grandchild, child for whom a Student is the legal guardian under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, Student status, employment status, marital status, eligibility for other coverage or any combination of those factors. In addition, enrolled unmarried children will be covered up to the age of 30 if they:

- 1) live within the service area of Blue Cross and Blue Shield of Illinois network for this Policy;
- 2) have served as an active or reserve member of any branch of the Armed Forces of the United States; and
- 3) have received a release or discharge other than a dishonorable discharge.

Coverage will continue for a child who is 26 years or more years of age, chiefly supported by the Student and incapable self-sustaining employment by reason of mental or physical disability. Proof of child's condition and dependence must be submitted within 31 days after the date the child ceases to qualify as a child for the reasons listed above. During the next two years, We may require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.

**Domestic Partner** means a companion of the same or opposite sex with whom the Student has entered into a Domestic Partnership. All provisions of this Policy that pertain to a spouse, also pertain to a Domestic Partner.

**Domestic Partnership** means a long-term committed relationship of indefinite duration with a person which meets the following criteria:

- You and Your Domestic Partner have lived together for at least 6 months;
- neither You nor Your Domestic Partner is married to anyone else or has another Domestic Partner;
- both You and Your Domestic Partner are at least 18 years of age and mentally competent to consent to contract;
- You and Your Domestic Partner reside together and intend to do so indefinitely;
- You and Your Domestic Partner have an exclusive mutual commitment similar to marriage; and
- You and Your Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

**Effective Date of Coverage** is 12:01 A.M. of the date on which a Policyholder's coverage under this Policy begins.

**EyeMed** is the Contracting Provider administrator. It provides the Contracting Providers and customer service to Covered Persons under this Student Vision Policy.

**EyeMed Contracting Provider** means a Provider who has entered into a contract with EyeMed to provide services to Covered Persons under this Student Vision Policy.

**First American Administrators (FAA)** is a wholly owned subsidiary of EyeMed and is the claims administrator for this Student Vision Policy.

**Identification Card** means the card EyeMed issues to the Student which is used to confirm a Student's coverage. It may show such information as the Student's name, identification number, and plan number or name.

**Institution** means an Institution of higher learning as defined in the Higher Education Act of 1965.

**Non-Contracting Provider** means a Provider who has not entered into a contract with EyeMed to provide services and supplies covered under this Student Vision Policy.

**Open Enrollment Period** is a period established by Your Institution which will be held at least annually at which time You and/or Your eligible Dependents may enroll for coverage under this Student Vision Policy.

**Policy** means this Policy issued by Blue Cross and Blue Shield of Illinois to the Institution, the Institution's application for coverage by this Student Vision Policy, the Covered Person's application for coverage, as appropriate, along with any exhibits, appendices, addenda and/or other required information.

**Proof of Loss** means a formal statement or Claim regarding a loss which provides sufficient information to allow BCBSIL to determine its liability for Covered Services. This includes, but isn't limited to:

- a completed Claim form;
- the Provider's itemized statement of services rendered and related charges; and
- medical records when requested by BCBSIL.



**Provider** means, for purposes of this Student Vision Policy, a licensed ophthalmologist or optometrist operating within the scope of his or her license or a dispensing optician. An EyeMed Contracting Provider is a Provider who has contracted with the vision care plan administrator, EyeMed. A Non-Contracting Provider has not contracted with EyeMed (even if such Provider is contracted with BCBSIL to render Covered Services under a medical/surgical health care plan.)

**Rescission** means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent attributable to a failure to timely pay premiums. A Rescission does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates.

**Student** means an individual Student who meets the eligibility requirements of the Institution for this Student Vision Policy.

**Vision Care Provider** means a Provider licensed under state law as an optometrist, osteopathic or medical physician, or a physician that has completed a residency in ophthalmology.

**Vision Examination** means a vision testing exam, including a determination as to the need for correction of visual acuity and prescribing lenses, if needed, that is performed by a Vision Care Provider who is operating within the scope of his/her license.

**Vision Materials** means those Materials used to aid in the correction of vision.

**Vision Plan** means a Policy, agreement, or arrangement, under which an entity undertakes to reimburse Claims for the cost of Vision Services and Vision Materials.

**Vision Services** means services provided by a Vision Care Provider.

**You and Your** means the Student and/or Dependents covered under this Student Vision Policy.



## Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St., 35<sup>th</sup> Floor  
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>  
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

|            | To receive language or communication assistance free of charge, please call us at 855-710-6984.                                     |
|------------|-------------------------------------------------------------------------------------------------------------------------------------|
| Español    | Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.                            |
| العربية    | للقول بمساعلة لغوية أو مساعدة لغوية مجانية، يرجى الاتصال بالرقم 855-710-6984.                                                       |
| 繁體中文       | 如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。                                                                                                 |
| Français   | Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984. |
| Deutsch    | Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.                              |
| ગુજરાતી    | ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો.                                                   |
| हिंदी      | निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।                                             |
| Italiano   | Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.                                            |
| 한국어        | 언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.                                                                                    |
| Navajo     | Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jì' hodíilni.          |
| کاسی       | برای دریافت کمک کنزائی یا توباطی ایگان، لطفاً شماره 855-710-6984 تماس بگیرید.                                                       |
| Polski     | Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.                                 |
| Русский    | Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.            |
| Tagalog    | Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.                              |
| اردو       | فہمیت ہیں زبان یا مواصلاتی مدد موصول کرنے کے لیے 855-710-6984 پر کلا کوئی۔                                                          |
| Tiếng Việt | Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.                                   |