





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.

**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 BCBSTX 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 BCBSTX for any services rendered or Claims paid by BCBSTX on behalf of the Student and/or any Dependents during the ten-day examination period.

**Blue Cross and Blue Shield of Texas**  
(Herein called BCBSTX, We, Us, Our)

Has issued this

**Student Vision Policy**

to

**University of Dallas**

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 Texas 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 Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company by:

James Springfield, President  
Blue Cross and Blue Shield of Texas

Blue Cross and Blue Shield of Texas, 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 TEXAS**

BCBSTX has contracted with EyeMed Vision Care, LLC (EyeMed), also referred to as the “network administrator”. EyeMed provides customer service and network administration services to Covered Persons enrolled in this BCBSTX Student Vision Policy. BCBSTX has also contracted with First American Administrators (FAA) to provide Claims administration services to Covered Persons enrolled in this BCBSTX Student Vision Policy. The relationship between BCBSTX, 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 “Our” is used, it means BCBSTX.

If You have any questions once You have read this Policy, call Us 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. If Covered Persons have any questions once they have read this Policy, they can call the number listed on their Identification Card. It is important that Covered Persons understand the protection this coverage gives them.

**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 BCBSTX Student Vision Plan! We are very happy to have You and pledge You Our best service.

## **Have a complaint or need help?**

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

### **Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation**

To get information or file a complaint with your insurance company or HMO:

Call: Blue Cross and Blue Shield of Texas

Toll-Free: 1-888-697-0683

Email: [BCBSTXComplaints@bcbstx.com](mailto:BCBSTXComplaints@bcbstx.com)

Mail: P. O. Box 660044, Dallas, TX 75266-0044

### **The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: Consumer Protection, MC:CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

## **¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

### **Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation**

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Blue Cross and Blue Shield of Texas

Teléfono gratuito: 1-888-697-0683

Correo electrónico: [BCBSTXComplaints@bcbstx.com](mailto:BCBSTXComplaints@bcbstx.com)

Dirección postal: P. O. Box 660044, Dallas, TX 75266-0044

### **El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: Consumer Protection, MC:CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

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## SCHEDULE OF BENEFITS

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

This Policy will pay without regard to any Medicare, Medicare Advantage, or Medicaid Coverage.

| 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.                                                                                                                                                                                                           |                                                                                                                                                                            |

## **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 BCBSTX Student Vision Policy Members.

### **SCHEDULE OF BENEFITS**

A Schedule of Benefits is included in this Policy showing 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.**  
**Sunday 10:00 A.M. to 7:00 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 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. Some courses may not fulfill the eligibility requirements. Please contact Your Institution for further information. Students must maintain their eligibility in order to maintain or continue coverage under this policy. Covered Students who lose eligibility status prior to the end of their enrolled coverage period will no longer be covered as of the first month following the loss of eligibility. Students enrolled for the Summer sessions will not experience a loss in coverage as long as they were covered immediately preceding Summer sessions. We maintain the right to investigate Student status and attendance records to verify that eligibility requirements have been met.

### **CLASSES OF ELIGIBLE PERSONS**

**Class 1:** All enrolled students and their eligible dependents are eligible for coverage under this policy.

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

Dependents, as defined by this Policy, of all Students are eligible for coverage under this Policy.

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 expression. 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:

- during the enrollment period established by the Institution; or
- within 31 days after the Student acquires a new Dependent; or
- 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 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 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 THIS VISION 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 Identification Card, be sure to say that You are a Member of the BCBSTX Student Vision Plan so that Your eligibility can be verified.

Visit EyeMed's website at [www.eyemedvisioncare.com/bcbstxind.com](http://www.eyemedvisioncare.com/bcbstxind.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 Effective Date of Coverage of the renewal of this Policy if a Student decides to renew coverage under this Student Vision Policy, and the Effective Date of Coverage 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.

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

## **COMPLAINT PROCEDURE**

If You are dissatisfied with an EyeMed Contracting Provider's quality of care, services, materials or facility, or with FAA's claims administration, You should first call EyeMed Customer Care Center at 1-888-782-3299 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 BCBSTX at the address noted below. You may also include written comments or supporting documentation.

BCBSTX 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 BCBSTX's receipt of Your Complaint. Upon final resolution, BCBSTX will notify You in writing of its decision.

### **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 BCBSTX within 180 days of Your notice of the denial. If You do not receive an explanation of Benefits 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 written denial, or a copy of the explanation of Benefits, if applicable;
- the item of vision coverage that You think was misinterpreted or inaccurately applied; and
- additional information from Your eye care Provider that will assist BCBSTX in completing its review of Your Appeal, such as documents, records, questions or comments.

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

Blue Cross and Blue Shield of Texas  
P.O. Box 660247  
Dallas, Texas 75266-0247  
Fax: 1-888-235-2936

Or send a secure email using Our message center by logging into:

Blue Access for Members<sup>SM</sup> (BAM) at BCBSTX.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.

### **MEMBER DATA SHARING**

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association or, if You do not reside in the Blue Cross and Blue Shield of Texas service area, by the Host Blues whose service area covers the geographic area in which You reside. The circumstances mentioned above may arise in various circumstances. As part of the overall Policy that Blue Cross and Blue Shield of Texas offers to you, if You do not reside in the Blue Cross and Blue Shield of Texas service area, Blue Cross and Blue Shield of Texas may facilitate Your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which You reside. To do this We may (1) communicate directly with You and/or (2) provide the Host Blues whose service area covers the geographic area in which You reside, with Your personal information and may also provide other general information relating to Your coverage under this Student Vision Policy the Institution has with Blue Cross and Blue Shield of Texas to the extent reasonably necessary to enable the relevant Host Blues to offer You coverage continuity through replacement coverage.

### **NON-AGENCY**

The Institution understands that this Vision Plan constitutes a Contract solely between the Institution and BCBSTX. BCBSTX 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 Texas. BCBSTX 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 BCBSTX. No person, entity, or organization other than BCBSTX shall be held accountable or liable to the institution for any of its obligations whatsoever on the on the part of BCBSTX other than those obligations created under other provision of this Student Vision Policy.



## **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 BCBSTX 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 (BCBSTX) 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 BCBSTX to be limited or harmed by any acts or failure to act on the part of any Student.
4. Our process to recover by subrogation or reimbursement will be conducted in accordance with Texas Civil Practice and Remedies Code Title 6, Chapter 140.
5. 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 Texas 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**

BCBSTX 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 BCBSTX is a party, including all persons covered under this Student Vision Policy. Under certain circumstances described in its contract with Plan Providers, BCBSTX may:

- receive substantial payments from Providers or suppliers with respect to goods, supplies and services furnished to all such persons for which BCBSTX 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 BCBSTX 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.

## **PAPER CHECK – AUTOMATIC CLEARING HOUSE/ELECTRONIC FUNDS TRANSFER**

BCBSTX will not charge an additional fee to a Payee if such person elects to receive the payment by paper check instead of by an automated clearinghouse transaction or other electronic funds transfer.

In addition to the **DEFINITIONS** of this Policy, the following definition is applicable to this provision:

**Payee** – an individual who resides in this state or a corporation, trust, partnership, association, or other private legal entity authorized to do business in this state that receives money as payment under an agreement.

## **STATE GOVERNMENT PROGRAMS**

All Benefits paid on behalf of a child or children under this Vision Policy must be paid to the Texas Health and Human Services Commission where;

- the Texas Health and Human Services Commission is paying Benefits pursuant to provisions in the Human Resources Code; and
- the parent who is covered under this Vision Plan has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support; and
- the Carrier receives written notice at its Administrative Office affixed to the Benefit Claim when the Claim is first submitted, that the Benefits claimed must be paid directly to the Texas Health and Human Services Commission.

## **TIME OF PAYMENT OF CLAIMS**

Benefits payable under this Student Vision Policy for any loss will be paid as soon as reasonably possible, but no later than the 60<sup>th</sup> day following receipt of due written Proof of Loss.

# **PREMIUMS AND REINSTATEMENT PROVISIONS**

## **PAYMENT OF PREMIUM**

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

Only if Your Institution receives Your initial payment, shall You be entitled to vision care services covered hereunder and then only for the Policy month for which such payment is received. If any required payment is not received by the Premium due date of the Policy month for You or 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 of the Policy Month in the event that Premium payments made by You.

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**

A Policy grace period of 31 days will be granted for the payment of the required Premiums. The Policy will remain in force during the grace period. If the required Premiums are not paid during the Policy grace period, insurance will end upon the expiration of the grace period. The Student will be liable for any unpaid Premium for the time the Policy was 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 BCBSTX directly to any Provider furnishing the Covered Services for which such payment is due, and BCBSTX is authorized by You to make such payments directly to such Providers. However, BCBSTX 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 BCBSTX's Benefit payment. You may be required to submit a copy of the assignment of Benefits to BCBSTX.

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, BCBSTX 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 BCBSTX will not interfere with Your relationship with any Provider. BCBSTX does not itself undertake to furnish Vision Services, but solely to make payments to Providers for Covered Services received by You. BCBSTX 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 BCBSTX. The use of an adjective such as BCBSTX 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.

## 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(s)** 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.

**BCBSTX, We, Us, or Our** means Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

**Claim** means a formal statement or claim regarding a loss which provides sufficient information to allow BCBSTX 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 written communication from the Student or on the Student'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 Covered 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 services shown in this Policy, and received from a Provider, for which Benefits will be paid under this Student Vision Policy.

**Dependent** means:

- a Student's lawful spouse; or
- a Student's child(ren).

"Child(ren)" used hereafter in this Policy means a natural child, a stepchild, foster child, adopted child (including a child for whom the Student is a party in a suit for which the adoption of the child is sought), a grandchild, or a child for whom the Student is the legal guardian under 26 years of age, regardless of the 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.

Coverage will continue for a child who is age 26 or older, chiefly supported by the Covered Person and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to Us 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, from time to time, require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.

**Effective Date of Coverage** is 12:01 a.m. of the date on which a Covered Person's coverage under this Student Vision Policy begins.

**EyeMed** is the Contracting Provider administrator. It provides the Contracting Providers and customer service to Covered Persons enrolled in 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 to confirm a Covered Person's coverage under this Student Vision Policy. It may show such information as the Covered Person'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 to Covered Persons 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 Texas to the Institution, any addenda, the Institution's application for Student Vision coverage, the Covered Person's application for coverage, as appropriate, along with any exhibits, appendices, addenda, and/or other required information.

**Premium** means the amount You are required to pay to obtain and continue, coverage under this Student Vision Policy.

**Proof of Loss (or Claim)** means a formal statement or Claim regarding a loss which provides sufficient information to allow for the determination of liability for Covered Services. This includes:

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

**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 BCBSTX to render Covered Services under a medical/surgical health care plan.)

**Rescission** means a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if:

- the cancellation or discontinuance of coverage has only a prospective effect; or
- the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required Premiums or contributions towards the cost of coverage.

**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, ophthalmologist, therapeutic optometrist, osteopathic physician, other physician who has completed a residency in ophthalmology, or dispensing optician who provides vision care services.

**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 licensed physician, optometrist, therapeutic optometrist, or ophthalmologist, 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.



## Non-Discrimination Notice

### Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator  
Attn: Office of Civil Rights Coordinator  
300 E. Randolph St., 35th Floor  
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960  
Email: [civilrightscoordinator@bcbsil.com](mailto:civilrightscoordinator@bcbsil.com)

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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

US Dept of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal:  
[ocrportal.hhs.gov/ocr/smartscreen/main.jsf](http://ocrportal.hhs.gov/ocr/smartscreen/main.jsf)  
Complaint Forms:  
[hhs.gov/civil-rights/filing-a-complaint/index.html](http://hhs.gov/civil-rights/filing-a-complaint/index.html)

This notice is available on our website at [bcbstx.com/legal-and-privacy/non-discrimination-notice](http://bcbstx.com/legal-and-privacy/non-discrimination-notice)

**ATTENTION:** If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

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|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Español<br>Spanish | ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor. |
| العربية<br>Arabic  | تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.                                                               |



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| 中文<br>Chinese       | 注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。                                                                                                                                                                                                                                         |
| Français<br>French  | ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.  |
| Deutsch<br>German   | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.      |
| ગુજરાતી<br>Gujarati | ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓક્સિડેલરી સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.                                                                    |
| हिंदी<br>Hindi      | ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।                                                                     |
| Italiano<br>Italian | ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.                                              |
| 한국어<br>Korean       | 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.                                                                                                                                                                                     |
| Diné<br>Navajo      | SHOOH: Diné bee yáníłt'ígogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'í'ígíí éí t'áá jiik'eh hóló. Kohji' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'í' hanidziih. |
| فارسی<br>Farsi      | توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 855-710-6984 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.                                                  |
| Polski<br>Polish    | UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.                                                                 |
| РУССКИЙ<br>Russian  | ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.              |
| Tagalog<br>Tagalog  | PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.                      |
| اردو<br>Urdu        | توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 855-710-6984 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔                                                                            |
| Việt<br>Vietnamese  | LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.                    |