Clemson University



STUDENT HEALTH PLAN VISION

Vision Coverage

August 1, 2026

VISION POLICY



South Carolina

Dear Member:

Blue Cross and Blue Shield of South Carolina (BlueCross) is pleased to provide your Vision Policy.

Please refer to the Benefits outlined in this Policy for all your vision care coverage.

We welcome you to our family of vision care coverage through BlueCross and look forward to meeting your vision care needs.

Blue Cross and Blue Shield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

IMPORTANT INFORMATION ABOUT YOUR VISION COVERAGE

The Benefits you receive will depend on whether the Provider of vision services is an In-Network Provider or Out-of-Network Provider. You will receive the maximum Benefits that can be paid if you use In-Network Providers. The amount you have to pay will increase when you do not use In-Network Providers.

If you use an Out-of-Network Provider, you have no protection from balance billing from the Provider.

HOW TO GET HELP

How to get help with vision questions:

- Dial 1-866-939-3633

Blue® Vision:

The Corporation provides you with access to ***Blue Vision***, a managed care vision product. Blue Vision is a product of EyeMed. EyeMed is an independent company that provides vision benefit services on behalf of BlueCross. Call 1-866-939-3633 to locate Providers, answer Plan specific Benefit questions, report issues or complaints and Plan limitations and exclusions. Automated information is available twenty-four (24) hours a day, seven (7) days a week.

You can also access EyeMed at www.eyemed.com to view Benefit information and access or print an Explanation of Benefits (EOB).

HOW TO FILE CLAIMS

In-Network Providers have agreed to file claims for vision care services they rendered to you. If you choose to use an Out-of-Network Provider, you are responsible for filing your claim.

Once the claim has been processed, you will have quick access to an EOB through www.eyemed.com or by contacting EyeMed's customer service. The EOB explains who provided the care, the kind of service or supply received, the amount billed and the amount paid. It also shows the reasons for denying or reducing a claim. Please see this Policy for more information.

Fees charges by a Provider for services other than a covered Benefit must be paid in full by the Member to the Provider. Such fees or materials are not covered under this Policy. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

If you receive services from an Out-of-Network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums outlined in the Vision Schedule of Benefits. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to First American Administrators, Inc., ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care:

FAA/EyeMed Vision Care, LLC.
Attn: OON Claims
P.O. Box 8504
Mason, Ohio 45040

For your convenience, a FAA/EyeMed out-of-network claim form is available at www.eyemed.com or by calling EyeMed's Customer Care Center at 1-866-939-3633.

Please refer to Article VIII of this Policy for more information on filing a claim.

SCHEDULE OF BENEFITS

Member Institution Contract Number: 25-85558-00, 02 through 06 and 08 through 13
Member Institution: Clemson University
Student Health Plan Vision
Member Institution's Effective Date: August 1, 2026

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of this Policy. In the event of a conflict between this Plan of Benefits and this Schedule of Benefits, this Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in this Policy.

To maximize your Benefits, seek vision services from an In-Network Provider. Please access EyeMed's website at www.EyeMed.com to find out if your Provider is an In-Network Provider.

GENERAL PROVISIONS **When a Benefit is listed below and has a dollar or percentage amount associated with it then the Benefit will be provided to Members subject to the terms of this Policy. When a Benefit has a "Non-Covered" notation associated with it, the Benefit is not available to the Member. All Benefits are subject to the dollar or percentage amount limitation associated with each Benefit in this Schedule of Benefits.**	
In addition to meeting the requirements contained in this Policy; the maximum age limitation to qualify as a Dependent Child is:	Twenty-six (26). When a Child turns age twenty-six (26), the Child's coverage will terminate at the end of the period for which a Premium has been accepted.
The column to the right identifies other group classifications, as defined by the Member Institution, that may participate in this Policy:	Domestic Partners
Any Copayments must be met before any expenses for Covered Services can be paid. This Schedule of Benefits applies during the 08/01 through 07/31 Benefit Frequency. The Anniversary Date is 08/01.	

VISION SCHEDULE OF BENEFITS (Blue Vision)		
Vision Care Services	**In-Network Providers**	**Out-of-Network Providers Reimbursement**
Comprehensive Exam with dilation as necessary	$20 Copayment	Up to $30
Pediatric Exam with dilation as necessary (for Members up to age 19)	$0 Copayment	Up to $30
Eye Exam by Eye360 Plus Provider (for Members 19 and older)	$0 Copayment	Up to $30
Retinal Imaging	$39	Non-Covered
Contact lens fit and follow-up:		
Standard contact lens fit and follow-up visit	$40 Copayment	Non-Covered
Premium contact lens fit and follow-up visit	10% off retail	Non-Covered
Pediatric contact lens fit and two follow-up visits (after Comprehensive Exam) for Members up to age 19:		
Standard contact lens fit and follow-up visit	$0 Copayment	Up to $35
Premium contact lens fit and follow-up visit	$0 Copayment, 10% off retail up to $55 Allowance	Up to $35
Frames Allowance*:	$0 Copayment up to $150 Allowance	Up to $75
Discount off balance over frame Allowance	20% off balance	Non-Covered
Frames Allowance with Eye360 Plus Provider*:	$0 Copayment up to $200 Allowance	Up to $75
Discount off balance over frame Allowance	20% off balance	Non-Covered

Vision Care Services	In-Network Providers	Out-of-Network Providers Reimbursement
Pediatric frames Allowance (for Members up to age 19)*:	Paid in full	Up to $60
Standard plastic lenses:		
Single vision	$20 Copayment	Up to $25
Bifocal	$20 Copayment	Up to $40
Trifocal	$20 Copayment	Up to $55
Lenticular	$20 Copayment	Up to $55
Standard Progressive	$85 Copayment	Up to $40
Premium Progressive tier 1	$105 Copayment	Up to $40
Premium Progressive tier 2	$115 Copayment	Up to $40
Premium Progressive tier 3	$130 Copayment	Up to $40
Premium Progressive tier 4	$85 Copayment, 20% off balance less $120 Allowance	Up to $40
Pediatric standard plastic lenses (for Members up to age 19):		
Single vision	$0 Copayment	Up to $25
Bifocal	$0 Copayment	Up to $40
Trifocal	$0 Copayment	Up to $55
Lenticular	$0 Copayment	Up to $55
Standard Progressive	$0 Copayment	Up to $55
Premium Progressive tier 1	$85 Copayment	Up to $55
Premium Progressive tier 2	$95 Copayment	Up to $55
Premium Progressive tier 3	$110 Copayment	Up to $55
Premium Progressive tier 4	$65 Copayment, 80% off balance less $120 Allowance	Up to $55

Vision Care Services	In-Network Providers	Out-of-Network Providers Reimbursement
Lens options (in addition to the cost of the lenses):		
UV coating	$15 Copayment	Non-Covered
Tint	$15 Copayment	Non-Covered
Standard scratch-resistance	$15 Copayment	Non-Covered
Standard polycarbonate	$40 Copayment	Non-Covered
Standard anti-reflective coating	$45 Copayment	Non-Covered
Premium anti-reflective coating tier 1	$57 Copayment	Non-Covered
Premium anti-reflective coating tier 2	$68 Copayment	Non-Covered
Premium anti-reflective coating tier 3	20% off retail	Non-Covered
Photochromic / transitions plastic	$75 Copayment	Non-Covered
Polarized	20% off retail	Non-Covered
All other lens options	20% off retail	Non-Covered

Vision Care Services	In-Network Providers	Out-of-Network Providers Reimbursement
Lens options for Members up to age 19 (in addition to the cost of the lenses):		
UV coating	$0 Copayment	Up to $5
Tint	$0 Copayment	Up to $5
Standard scratch resistance	$0 Copayment	Up to $5
Standard polycarbonate	$0 Copayment	Up to $5
Standard anti-reflective coating	$45 Copayment	Non-Covered
Premium anti-reflective coating tier 1	$57 Copayment	Non-Covered
Premium anti-reflective coating tier 2	$68 Copayment	Non-Covered
Premium anti-reflective coating tier 3	80% of charge	Non-Covered
Photochromic / transitions plastic	$0 Copayment	Up to $5
Polarized	20% off retail	Non-Covered
Oversized	20% off retail	Non-Covered
All other lens options	20% off retail	Non-Covered
Contact lenses (in lieu of frames/lenses):**		
Conventional	$0 Copayment up to $150 Allowance, 15% off balance over $150	Up to $150
Disposable	$0 Copayment up to $150 Allowance	Up to $150
Medically Necessary	$0 Copayment, Paid in Full	Up to $210

Vision Care Services	In-Network Providers	Out-of-Network Providers Reimbursement
Pediatric contact lenses (for Members up to age 19):**		
Conventional	$0 Copayment, Paid in Full	Up to $112
Disposable	$0 Copayment, Paid in Full	Up to $112
Medically Necessary	$0 Copayment, Paid in Full	Up to $210
Frequency:		
Examination	One (1) per Member per Benefit Year	
Lenses or contact lenses	One (1) per Member per Benefit Year	
Frame	One (1) per Member per Benefit Year	
Laser vision correction	15% off retail price or 5% off promotional price	Non-Covered

*Additional frames and lenses are covered at 40% off for a complete pair of eyeglasses (frames and lenses) once benefits for In-Network Providers have been used

**Additional contact lenses are covered at 15% off for conventional lenses once benefits for In-Network Providers have been used

STUDENT BLANKET VISION INSURANCE

Blue Cross and Blue Shield of South Carolina, referred to in this Policy as “Corporation”, issues this Policy to the Policyholder named in the Insurance Information Schedule to insure the Students of a school.

The Effective and Termination Dates for coverage under this Policy are as shown in the Schedule of Benefits and Rates. All time periods begin and end at 12:01 A.M., local time, at the Policyholder’s address.

The following pages form a part of this Policy as fully as if the signatures below were on each page.

This Policy is executed for the Company by its President.

BLUE CROSS BLUE SHIELD
OF SOUTH CAROLINA
An Independent Licensee of the Blue Cross
and Blue Shield Association



By: _____
Title: President
Blue Cross and Blue Shield Division

Address: I-20 East @ Alpine Road
Columbia, South Carolina 29219-0001

Date: August 12, 2026

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RATE PAGE

Member Institution Name: Clemson University
Member Institution Number(s): 25-85558-00, 02 through 06 and 08 through 13
Member Institution's Effective Date: August 1, 2026

Blue Vision:	Rate below is per Employee per month:	
	Single:	$2.39
	Two-Person:	$4.78
	Employee + 2 (Children):	$7.17
	Employee + 3 (Children):	$9.56
	Employee + 4 (Children):	$11.95

Reports for certain programs will be provided for a fee as agreed to by the Member Institution and the Corporation.

ARTICLE I - DEFINITIONS

Capitalized terms that are used in this Policy shall have the following defined meanings:

Adverse Benefit Determination: a claim denial, Benefit or payment reduction or termination of vision services.

Allowance: the maximum dollar amount of coverage for frames, lenses, lens options or contact lenses under this Policy. The Allowances act like a credit toward the retail price. So long as the Member selects eyewear having a retail price that is less than or equal to the Allowance, the Member will incur no out-of-pocket expense for eyewear at the time of service, apart from any applicable Copayment. If the selected eyewear has a retail price that exceeds the Allowance, the Member will be responsible only for the balance (i.e. retail price minus the Allowance).

Authorized Representative: an individual (including a Provider) whom the Member designates in writing to act on such Member's behalf.

Benefit(s): vision care services or supplies that are:

1. Included in Article III of this Policy; and,

2. Not limited or excluded under the terms of this Policy.

Benefit Detail Report: the document (in electronic or hardcopy form) maintained by the Corporation which reflects the benefits selected by the Member Institution and submitted to the Corporation which outlines the Benefits to be offered under the Policy. The Corporation shall administer the Policy in accordance with the terms of the Benefit Detail Report. In the event of any conflict between the Benefit Detail Report and this Policy or the Schedule of Benefits, the Benefit Detail Report shall control.

Benefit Frequency: the period of time in which a Benefit is payable as set forth on the Schedule of Benefits. The Benefit Frequency begins on the Member Institution's Effective Date. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

Child: a Student's child, whether a natural child, adopted child, foster child, stepchild or child for whom a Student has custody or legal guardianship. The term "Child" also includes an Incapacitated Dependent, and a child of a divorced or divorcing Student who, under a valid court order, has a right to enroll under the Policy. The term "Child" does not include the Spouse of an eligible child.

Comprehensive Eye Examination: a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one (1) session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Contract: the Request For Proposal between the Corporation and the South Carolina Student Health Insurance Consortium (SCSHIC) including the Member Institution Application, Benefit Detail Report, Policy, Schedule of Benefits and all endorsements, amendments, riders or addenda.

Copayment: the designated amount, if any, shown in the Schedule of Benefits which each Member must pay to a Provider before Benefits are payable per Benefit Frequency.

Corporation: Blue Cross and Blue Shield of South Carolina.

Covered Services: services provided to the Member which are included on the Schedule of Benefits, subject to applicable Copayments and maximum amount limitations.

Dependent(s): an individual who is:

1. A Student's Spouse;

2. A Child under the age set forth on the Schedule of Benefits;

3. An Incapacitated Dependent; or,

4. A Domestic Partner, if Domestic Partners are listed as covered on the Schedule of Benefits.

Domestic Partner: a Dependent**)** who:

1. Is unmarried, at least eighteen (18) years of age, mentally competent, resides with the other partner and intends to reside with the other partner for an indefinite amount of time;

2. Is not related to the other partner by adoption or blood;

3. Is the sole Domestic Partner of the other partner, with whom such Domestic Partner has a close committed and personal relationship, and has been a member of the domestic partnership for the last twelve (12) months;

4. Agrees to be jointly responsible for the basic living expenses and welfare of the other partner; and;

5. Is financially interdependent. Financial interdependence is demonstrated by submission of three (3) or more of the following documents:

    a. a joint mortgage or lease;

    b. a designation of one (1) of the partners as beneficiary in the other partner's Will or life insurance policy;

    c. a durable property and health care powers of attorney;

    d. a joint title to an automobile;

    e. a joint bank account or credit account; or;

    f. such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

If Domestic Partners are listed as covered on the Schedule of Benefits, the Student and applicant for coverage as a Domestic Partner will be required to sign an Affidavit of Domestic Partnership. The Corporation reserves the right to request documentation of any of the foregoing prior to commencing coverage of the Domestic Partner.

Formulary: a list, provided by EyeMed, of Vision Materials and contact lenses which are covered under the Policy and preferred for use.

Grace Period: the thirty-one (31) day period for the payment of any Premium due, except the first Premium, during which time the Covered Services are paid by the Corporation, unless the Member Institution gives the Corporation written notice of intent to discontinue the Contract or this Policy prior to the date the next Premium is due in accordance with the terms of the Policy. There is no Grace Period for the payment of the first Premium.

HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.

Identification Card: the card issued by the Corporation to a Member that contains the Member's identification number.

Incapacitated Dependent: a Child who is:

1. Incapable of financial self-sufficiency by reason of total disability; and,

2. Dependent upon the Student for at least fifty-one (51) percent of the Dependent's support and maintenance.

A Child must meet both of these requirements to qualify as an Incapacitated Dependent. A Child who is not incapacitated by the maximum Dependent Child age listed on the Schedule of Benefits will not be covered.

In-Network Provider: a Provider who has signed a Preferred Provider Agreement with the PPO.

Late Enrollment: the time period during which a Student or eligible Dependent enrolls for coverage under this Policy other than during:

1. The first period in which the Student or Dependent is eligible to enroll if such initial enrollment period is at least thirty (30) days; or,

2. A Special Enrollment period (as set forth in Article II(C)(6)).

Low Vision: a severe visual problem that is not correctable with standard lenses and:

1. when the best-corrected acuity is 20/200 or less in the better eye with best conventional spectacle or contact lens prescription; or,

2. when there can be a demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point or the widest diameter subtends an angle less than 20 degrees in the better eye.

Low Vision Aids: supplies that are classified as follows:

1. Spectacle-mounted magnifiers: a magnifying lens is mounted in spectacles (this type of system is called a microscope) or on a special headband. This allows use of both hands to complete the close-up task, such as reading;

2. Handheld or spectacle-mounted telescopes: these miniature telescopes are useful for seeing longer distances, such as across the room to watch television, and can also be modified for near (reading) tasks;

3. Handheld and stand magnifiers: these can serve as supplements to other specialized systems and are convenient for short-term reading of such things as price tags, labels and instrument dials. Both types can be equipped with lights; or,

4. Video magnification: table-top (closed-circuit television) or head-mounted systems enlarge reading material on a video display. Some systems can be used for distance viewing tasks. These are portable systems and can be used with a computer or Computer Display. Image brightness, image size, contrast, foreground/background color and illumination can be customized.

Low Vision Supplemental Testing: diagnostic evaluation beyond the Comprehensive Eye Examination and includes a history of functional difficulties that involves such things as reading, activities in the kitchen, glare problems, travel vision, the workplace, television viewing, school requirements, hobbies and interests. Preliminary tests may include assessment of ocular functions such as color vision and contrast sensitivity. Measurements will be taken of the Member's visual acuity using special low vision test charts which include a larger range of letters or numbers to more accurately determine a starting point for assessing the level of impairment. Visual fields may also be evaluated. A specialized refraction must be performed with each eye thoroughly examined. The eyecare professional may prescribe various treatment options, including Low Vision Aids, as well as assist the Member with identifying other resources for vision and lifestyle rehabilitation.

Medical Supplies: supplies that are:

1. Prescribed by a Provider acting within the scope of such Provider's license;

2. Are not available on an over-the-counter basis (unless such supplies are provided to a Member in a Provider's office and should not be included as part of the treatment received by the Member); and,

3. Are not prescribed in connection with any treatment or Benefit that is excluded under this Policy.

Medically Necessary Contact Lenses:

1. Keratoconus where the Member is not correctable to 20/30 in either or both eyes using standard spectacle lenses or the Provider attests to the specified level of visual improvement;

2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;

3. Anisometropia of 3D in spherical equivalent or more; or,

4. Vision for a Member can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

Member: a person insured under this Policy.

Member Effective Date: the date on which a Student or Dependent is covered for Benefits under the terms of Article II of this Policy.

Member Institution: the entity participating in the SCSHIC whose Students and their Dependents are eligible for coverage under this Policy and who is identified as the member institution on the Schedule of Benefits.

Member Institution's Effective Date: 12:01 a.m. EST on the date listed on the Schedule of Benefits.

Membership Application: any mechanism agreed upon by the Corporation and the Member Institution or SCSHIC for transmitting necessary Member enrollment information from the Member Institution or SCSHIC to the Corporation.

Out-of-Network Provider: a Provider, located within the PPO Service Area, who has not signed a Preferred Provider Agreement with the PPO.

Plan: any program that provides benefits or services for vision care, including:

1. Individual or group coverage, whether insured or self-insured; and,

2. Coverage under a governmental plan or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan for purposes of this Policy.

Policy: this document which reflects the Benefits offered based on the Benefit Detail Report. The Policy includes the Schedule of Benefits.

Preferred Provider Organization (PPO): a network of Providers and retail chain stores within the PPO Service Area that has signed a Preferred Provider Agreement.

Preferred Provider Organization (PPO) Service Area: the geographical area where the PPO is located.

Premium: the amount paid to the Corporation by the Student for coverage under this Policy. Payment of Premiums by the Student, or the Member Institution or SCSHIC on such Student's behalf, constitutes acceptance by the parties of the terms of this Policy and the Contract.

Provider: a licensed physician or optometrist who is operating within the scope of such Provider's license or a dispensing optician.

Refraction: a diagnostic test to determine the presence or absence of any refractive error (nearsightedness, farsightedness or astigmatism). Refraction includes the writing of a prescription by the Provider for any refractive error.

Schedule of Benefits: the pages of this Policy, so titled, which specify the coverage provided and the applicable Copayments, Allowance and Benefit limitations.

South Carolina Student Health Insurance Consortium (SCSHIC): the entity contracted with the Member Institutions.

Special Enrollment: the time period during which a Student or eligible Dependent who is not enrolled for coverage under this Policy may enroll for coverage due to the involuntary loss of other coverage or under permitted circumstances described in Article II of this Policy.

Spouse: any individual who is legally married under any state law.

Student: a student of the Member Institution who is eligible and insured for coverage under the Policy.

Vision Examination: any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

Vision Materials: those materials shown on the Schedule of Benefits which are used to aid in the correction of vision. Vision Materials include, but are not limited to, lenses, lens options, frames and contact lenses.

ARTICLE II – ELIGIBILITY FOR COVERAGE

A. ELIGIBILITY

1. Every Student is eligible to enroll (and to enroll such Student's Dependents) for coverage under this Policy.

2. Dependents are not eligible to enroll for coverage under this Policy without the sponsorship of a Student covered under this Policy.

3. The Student must furnish written proof of the requirements for an Incapacitated Dependent, as outlined in Article I, to the Member Institution no later than thirty-one (31) days after the Child's attainment of the maximum age listed on the Schedule of Benefits. The Student will provide proof upon request.

B. ELECTION OF COVERAGE

Any Student may enroll for coverage under this Policy for such Student and such Student's Dependents by completing and filing a Membership Application with the Member Institution. Dependents must be enrolled within sixty (60) days of the date on which they first become Dependents. Students and Dependents may also enroll if eligible under the terms of any Late Enrollment or Special Enrollment procedure.

The Student is required to submit a marriage license and file it with the Member Institution. The Corporation reserves the right to request documentation of such marriage.

If Domestic Partners are listed as covered on the Schedule of Benefits, the Student and Domestic Partner are required to complete an Affidavit of Domestic Partnership and file it with the Member Institution. The Member Institution and/or Student will submit the affidavit with the Membership Application to the Corporation.

C. COMMENCEMENT OF COVERAGE

Coverage under this Policy will commence as follows, provided that coverage will not be effective more than sixty (60) days before the Corporation receives such Student's Membership Application:

1. Students and Dependents Eligible After the Member Institution's Effective Date.

   Students and Dependents who become eligible for coverage after the Member Institution's Effective Date and have elected coverage within sixty (60) days of such eligibility will have coverage as of the date of such eligibility.

2. Dependents Resulting from Marriage.

   Dependents resulting from the marriage of a Student will have coverage upon enrollment provided they have been enrolled for coverage within sixty (60) days after marriage and appropriate Premiums must be paid to the Corporation for such Dependents to have coverage from the date of the marriage.

3. Dependents Resulting from Domestic Partnership.

   If Domestic Partners are listed as covered on the Schedule of Benefits, Dependent(s) resulting from the creation of a domestic partnership must apply for coverage within thirty-one (31) days after domestic partnership and appropriate Premiums must be paid to the Corporation for such Dependent(s) to have coverage from the date of the domestic partnership. If a Dependent resulting from a domestic partnership is not enrolled within thirty-one (31) days after the domestic partnership, coverage will begin on the date chosen by the Member Institution and after the payment of the applicable Premium.

   A Domestic Partner's Child, who has not been legally adopted by the Student, must be living with the Student and Student's Domestic Partner on a full-time basis in a permanent parent-child relationship. In addition, the Child must meet the qualifications of Dependent and Child as described in the Policy.

   The Student and/or Student's Domestic Partner may be required to furnish written proof of a Child's eligibility for coverage as a Domestic Partner's Child.

   Domestic Partners are not considered to be tax-qualified dependents by the Internal Revenue Service (IRS) unless they satisfy specific statutory requirements and the Student declares the Domestic Partner or their children on the Student's tax return. Therefore if the Student elects Domestic Partner coverage, the IRS may tax the Student for the value of Benefits provided. The Student should consult such Student's own personal tax advisor to determine how these tax implications affect the Student.

4. Newborn Children.

   A newborn Child will have coverage upon the date of the Child's birth provided the Child has been enrolled for coverage (and the coverage has been paid for) within sixty (60) days after the Child's birth.

5. Adopted Children.

   For an adopted Child of a Student, coverage shall commence as follows, provided that the Child has been enrolled for coverage (and the coverage has been paid for) within sixty (60) days after the applicable event:

   a. Coverage shall be retroactive to the Child's date of birth when a decree of adoption is entered within sixty (60) days after the date of the Child's birth;

   b. Coverage shall be retroactive to the Child's date of birth when adoption proceedings have been instituted by the Student within sixty(60) days after the date of the Child's birth and if the Student has obtained temporary custody of the Child; or,

   c. For an adopted Child other than a newborn, coverage shall begin as of the date of adoption or placement for adoption or, if earlier, when temporary custody of the Child begins. However, such coverage shall only continue for one (1) year unless a decree of adoption is entered, in which case coverage shall be extended so long as such Child is otherwise eligible for coverage under the terms of this Policy.

   If an adopted Child is not enrolled within sixty (60) days after the applicable event set forth in (a)-(c) above, coverage will begin on the date chosen by the Member Institution and upon the payment of the applicable Premium.

6. Special Enrollment.

   In addition to enrollment under Article II (C)(2-5), the Corporation shall permit a Student or Dependent who is not enrolled to enroll within sixty (60) days of when the Student or Dependent loses other coverage that qualifies as "minimum essential coverage" under federal law, or certain pregnancy-related or medically needy coverage under the Medicaid program, or otherwise qualifies for a Special Enrollment period under federal law. Contact the Corporation for more information.

D. DEPENDENT CHILD'S ENROLLMENT

1. A Dependent Child will not be denied enrollment for any of the following reasons:

   a. Being born out of wedlock;

   b. Not being claimed as a Dependent on the Student's federal tax return; or,

   c. Not residing with the Student.

2. A Dependent's eligibility for or receipt of Medicaid assistance will not be considered in enrolling that Dependent for coverage under this Policy. For a Dependent to be covered under this Policy, the required Premium must be paid.

3. Absent the sponsorship of a Student, Dependents are not eligible to enroll for coverage under this Policy.

E. MEMBERSHIP APPLICATION

The Corporation will only accept a Membership Application submitted by the Member Institution on behalf of each Student. The Corporation will not accept a Membership Application directly from a Student or Dependent.

F. MEMBER CONTRIBUTIONS

The Member is solely responsible for making all payments for any Premium.

G. DISCLOSURE OF MEDICAL INFORMATION

The Member agrees that the Corporation may obtain claims information, medical records and other information necessary for the Corporation to process a claim for Benefits under this Policy.

ARTICLE III – BENEFITS

A. PAYMENT

The payment for Benefits is subject to all terms and conditions of this Policy. In the event of a conflict between this Policy and the Schedule of Benefits, the Schedule of Benefits controls. Oral statements cannot alter the terms of the Policy or Schedule of Benefits. The Corporation will only pay for Benefits:

1. Performed or provided on or after the Member Effective Date;

2. Performed or provided prior to termination of coverage;

3. Provided by a Provider, within the scope of such Provider's license;

4. That are not subject to an exclusion under Article IV of this Policy;

5. After the payment of all required Copayments; and,

6. That comply with the Corporation's corporate medical policy unless otherwise indicated in the Benefit Detail Report.

The amount payable for Benefits is determined as set forth in this Policy and on the Schedule of Benefits. Benefits are subject to the limitations and requirements set forth in this Policy and on the Schedule of Benefits. Payment for Benefits will not exceed the Allowance.

B. ASSIGNMENT

Benefits under the Policy may not be assigned.

C. SPECIFIC COVERED BENEFITS

If all of the following requirements are met, the Corporation will pay for the Benefits described in Article III (D):

1. All of the requirements of Article III must be met;

2. The Benefit must be listed in Article III;

3. The Benefit must not have a "**Non-Covered**" notation associated with it on the Schedule of Benefits;

4. The Benefit (separately or collectively) must not exceed the dollar or other limitations contained on the Schedule of Benefits; and,

5. The Benefit must not be subject to one (1) or more of the exclusions set forth in Article IV.

D. BENEFITS

COMPREHENSIVE EYE EXAMINATION

A Member is eligible for one (1) Comprehensive Eye Examination in each Benefit Frequency.

IN-NETWORK PROVIDER BENEFITS

The Member must pay any Copayment or cost above the Allowance set forth on the Schedule of Benefits at the time the Covered Service is provided. Benefits will be paid to the In-Network Provider who will file a claim with EyeMed.

LOW VISION

A Member is eligible for Low Vision Supplemental Testing and Low Vision Aids if set forth on the Schedule of Benefits and if the Member has severe visual problems that are not correctable with standard lenses.

OUT-OF-NETWORK PROVIDER BENEFITS

The Member must pay an Out-of-Network Provider the full cost at the time of service is provided and file a claim with EyeMed. EyeMed will reimburse the Member for the Out-of-Network Provider Benefits up to the maximum dollar amount shown on the Schedule of Benefits.

VISION MATERIALS

If a Vision Examination results in a Member needing corrective Vision Materials for the Member's visual health and welfare, those Vision Materials prescribed by the Provider will be supplied, subject to certain limitations and exclusions of the Policy, as set forth on the Schedule of Benefits.

ARTICLE IV - EXCLUSIONS AND LIMITATIONS

THE CORPORATION WILL NOT PAY ANY AMOUNT FOR THE SERVICES AND PRODUCTS LISTED IN THIS ARTICLE IV EXCEPT: (1) SERVICES ARE RENDERED BY A HEALTH CARE PROVIDER AS PART OF A VALUE-BASED PROGRAM OR (2) IF REQUIRED BY LAW.

ACTS OF WAR

Illness contracted or injury sustained as a result of a Member's participation as a combatant in a declared or undeclared war, or any act of war, or while in military service.

PROVIDER FEES FOR NON-COVERED SERVICES

Fees charged by a Provider for services other than a covered Benefit must be paid in full by the Member to the Provider. Such fees or materials are not covered under the Policy.

VISION EXCLUSIONS

No Benefits will be paid for services or materials connected with or charges arising from unless specified in Article III or the Schedule of Benefits:

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;

2. Medical and/or surgical treatment of the eye, eyes or supporting structures;

3. Any Vision Examination or Vision Materials;

4. Any Vision Examination, corrective eyewear or safety eyewear required by a Member Institution as a condition of employment;
5. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;

6. Plano (non-prescription) lenses and/or contact lenses;

7. Non-prescription sunglasses;

8. Two (2) pair of glasses in lieu of bifocals;

9. Services or materials provided by any other group benefit plan providing vision care;

10. Services rendered after the date a Member ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Member are within thirty-one (31) days from the date of such order; or,

11. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

WORKERS' COMPENSATION

This Policy is not a Workers' Compensation policy. This Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.

ARTICLE V – TERMINATION OF THIS POLICY

A. GENERALLY

TERMINATION OF STUDENT'S COVERAGE AND ALL OF SUCH STUDENT'S DEPENDENTS' COVERAGE WILL OCCUR ON THE EARLIEST OF THE FOLLOWING CONDITIONS:

1. The date this Policy is terminated pursuant to Article V(B)-(I);

2. The date a Student ceases to be eligible for coverage as set forth in Article II;

3. In addition to terminating when a Student's coverage terminates, a Dependent Spouse's coverage terminates on the date of entry of an order or decree ending the marriage between the Dependent Spouse and the Student regardless of whether such order or decree is subject to appeal;

4. In addition to terminating when a Student's coverage terminates, a Domestic Partner and the children of the Domestic Partner's coverage terminates when the domestic partnership is dissolved. An Affidavit of Termination of Partnership must be completed by the Student and submitted to the Member Institution and/or the Corporation within thirty (30) days of dissolution, and the Member Institution must send a Membership Application to cancel this person from coverage.

   All other Policy termination of coverage provisions apply to a Domestic Partner and the children of the Domestic Partner;

5. In addition to terminating when a Student's coverage terminates, a Child's coverage terminates when that individual no longer meets the definition of a Child under this Policy;

6. In addition to terminating when a Student's coverage terminates, an Incapacitated Dependent's coverage terminates when that individual no longer meets the definition of an Incapacitated Dependent; or,

7. Upon the death of the Student.

B. TERMINATION FOR FAILURE TO PAY PREMIUMS

1. If the Premium remains unpaid after the Grace Period, the coverage for the Member's Policy shall automatically terminate, without prior notice to the Member Institution, immediately after the last day of the Grace Period.

2. During the Grace Period, the Corporation will pay for Covered Services for Benefits (including Prescription Drugs) obtained by Members during the Grace Period.

3. In the event of termination for failure to pay Premiums, Premiums received by the Corporation after the Grace Period will not automatically reinstate this Policy absent written agreement by the Corporation. The Corporation will refund the amount of any late Premium paid if this Policy is not reinstated, except that portion relating to coverage provided prior to or during the Grace Period.

C. UNIFORM TERMINATION OF COVERAGE

1. The Corporation may terminate coverage under this Policy if:

   a. The Corporation ceases to offer coverage of the type of individual health insurance coverage provided by this Policy and provides notice to the Student's Member Institution at least ninety (90) days prior to the date of the discontinuation of such coverage;

   b. The Corporation offers to each Member Institution's Students provided coverage of this type the option to purchase any other individual health insurance currently being offered by the Corporation in the individual market; and,

   c. The Corporation acts uniformly without regard to the claims experience of the Member Institution or any Health Status-Related Factor relating to any Members, Students or Dependents who may become eligible for such coverage.

2. If the Corporation elects to discontinue offering all individual health insurance coverage in South Carolina, coverage under this Policy may be discontinued by the Corporation only:

   a. In accordance with applicable state law;

   b. If the Corporation provides notice to the Department of Insurance (DOI) and to the Member Institution of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage;

   c. If all individual health insurance coverage issued or delivered for issuance in South Carolina is discontinued and coverage under such health benefit coverage in such market is not renewed; and,

   d. If the Corporation will not issue any individual health insurance coverage in the market during the five (5) year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

D. REINSTATEMENT

The Corporation in its discretion may reinstate coverage under this Policy that has been terminated if:

1. The Member requests reinstatement;

2. The unpaid Premium is not more than sixty (60) days overdue;

3. The Member has paid all overdue and currently due Premiums; and,

4. The Corporation approves the Member's request for reinstatement.

Coverage under this Policy will be reinstated on the date the coverage lapsed if requirements (1) through (4) above have been met. If the request is not approved, the Corporation will refund the Premium submitted. If the Corporation fails to act on the request, coverage under this Policy will be reinstated upon the Corporation's acceptance of the Premium. All terms under this Policy, including any amendments, which existed before the due date will remain in effect. The Member should submit any claims incurred during the period of lapsed coverage to the Corporation for processing under this Policy.

E. EXTENSION OF BENEFITS FOLLOWING TERMINATION

If this Policy is terminated under this Article V(E), or a Member participating in this Policy is terminated, all rights to receive Covered Services provided on or after the date of termination will automatically cease.

F. MEMBER INSTITUTION AND SCSHIC ARE AGENTS OF MEMBERS

By accepting Benefits, a Member agrees that the Member Institution and SCSHIC are the Member's agents for all purposes of any notice under this Policy. The Member further agrees that notifications received from, or given to, the Member Institution or SCSHIC by the Corporation are notification to the Students except for any notice required by state or federal law to be given to the Members by the Corporation.

ARTICLE VI – CONVERSION AND CONTINUATION OF COVERAGE

A. CONVERSION FOR DIVORCED SPOUSES

Upon the entry of a valid order or decree of divorce between a Student and such Student's Dependent Spouse, the divorced Spouse shall be entitled (upon request) to a conversion policy, without evidence of insurability, upon submission of an application of insurance made to the Corporation within sixty (60) days following the divorce decree and upon payment of the appropriate Premium. Any probationary periods set forth in the conversion policy that had previously been met under this Policy shall be considered as being met to the extent that such probationary periods were met under this Policy.

B. CONTINUATION OF COVERAGE FOR A NON-INCAPACITATED DEPENDENT CHILD

If a non-incapacitated Child covered under this Policy is no longer eligible because of reaching the maximum age limit, such Child may apply for a new policy upon the attainment of the limiting age. The Child is entitled to have issued to him or her, without evidence of insurability, upon application made to the Corporation within thirty-one (31) days following the attainment of the age and upon payment of the appropriate Premium, an individual policy of accident and health insurance, as applicable. The policy shall provide the coverage then being issued by the Corporation which is closest to, but not greater than, the terminated coverage. Any probationary or waiting period set forth in the policy must be considered as met to the extent coverage was in force under the prior Policy. Contact the Corporation for more information.

C. VOLUNTARY MEDIGAP

The Corporation will make voluntary rated health insurance coverage available to any currently insured Student for up to three (3) months from the time the Student either graduates from or discontinues enrollment at a Member Institution.

Premiums for voluntary rated plans are subject to be paid by the Student directly to the Corporation.

ARTICLE VIII - CLAIMS FILING AND APPEAL PROCEDURES

NOTICE OF CLAIM

Written notice of claim must be given to EyeMed within thirty (30) days after the occurrence or commencement of any loss covered by the Policy or as soon as is reasonably possible. Notice given by or for the Member to EyeMed at EyeMed's home office, to EyeMed's authorized administrator or to any of EyeMed's authorized agents with sufficient information to identify the Member will be deemed as notice to EyeMed.

CLAIM FORMS

EyeMed will furnish claim forms to the Member within fifteen (15) days after notice of claim is received. If EyeMed does not provide the forms within that time, the Member may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss.

PROOF OF LOSS

Written proof of loss must be furnished to EyeMed at EyeMed's home office within ninety (90) days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one (1) year from the time proof is required.

TIME PAYMENT OF CLAIMS

Any Benefit payable under the Policy will be paid immediately, but not more than thirty (30) days, upon receipt of due written proof of loss.

PAYMENT OF CLAIMS

The Corporation may pay all Benefits directly to the Member upon receipt of due proof of loss when an Out-of-Network Provider renders services. When payment is made directly to the Member, the Member is responsible for any payment to the Provider. Where a Member has received Benefits from an In-Network Provider, the Corporation will pay Benefits directly to such In-Network Provider. Benefits unpaid at death may be paid, at the Corporation's option, either to the Member's beneficiary or estate.

ARTICLE IX - GENERAL PROVISIONS

AMENDMENT

Upon thirty (30) days prior written notice, the Corporation may unilaterally amend this Policy when required by federal or state law. Increases in the Benefits provided or decreases in the Premium are effective without such prior notice. Upon thirty-one (31) days' notice, the Corporation may increase the Premium. Notice of an amendment will be effective when addressed to the Member Institution or SCSHIC. The Corporation has no responsibility to provide individual notices to each Member when an amendment to this Policy has been made.

AUTHORIZED REPRESENTATIVES

A Provider may be considered a Member's Authorized Representative without a specific designation by the Member when the preauthorization request is for urgent care claims. A Provider may be a Member's Authorized Representative with regard to non-urgent care claims only when the Member gives the Corporation or the Provider a specific designation, in a format that is reasonably acceptable to the Corporation to act as an Authorized Representative. If the Member has designated an Authorized Representative, all information and notifications will be directed to that representative unless the Member gives contrary directions.

CLERICAL ERRORS

Clerical errors by the Corporation will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

GOVERNING LAW

This Policy (including the Schedule of Benefits) is governed by and subject to applicable federal law. If and to the extent that federal law does not apply, this Policy is governed by and subject to the laws of the State of South Carolina. If federal law conflicts with any state law, then such federal law shall govern. If any provision of this Policy conflicts with such law, this Policy shall automatically be amended solely as required to comply with such state or federal law, and the Corporation shall be entitled to adjust the Premium upon thirty-one (31) days written notice.

IDENTIFICATION CARD

Identification Cards are for identification only. Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Member whose Premium has been paid. Any person receiving Covered Services to which the person is not entitled will be responsible for the charges.

INCONTESTABILITY

The validity of this Policy may not be contested after it has been in force for two (2) years from its date of issue. No statement relating to insurability, except fraudulent misstatements, made by any Member may be used in contesting the validity of the coverage with respect to which the statement was made after the coverage has been in force for a period of two (2) years unless it is contained in a written instrument signed by the person making the statement. The provision does not preclude assertion at any time of defenses based upon the person's ineligibility for coverage under the Policy or upon other provision in the Policy.

INFORMATION AND RECORDS

The Corporation is entitled to obtain records and other information as it may reasonably require from any Member or Provider incident to the treatment, payment and healthcare operations for the administration of the Benefits hereunder and the attending Provider's certification as to the medical necessity for care or treatment. Payment for Benefits may be denied until the requested records, documentation or information is received.

LEGAL ACTIONS

No Member can bring an action at law or in equity to recover on the Policy until more than sixty (60) days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of six (6) years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Member resides, the limit is extended to meet the minimum time allowed by such law.

LIMITED-SCOPE VISION BENEFITS

This Policy is a limited-scope vision Benefits Plan. The Benefits are substantially for the administration of Comprehensive Eye Examinations and dispensing Visions Materials and are provided under a separate policy, certificate or contract of insurance, or are otherwise not an integral part of a group health plan. If this Policy is sold in conjunction with a health Plan Benefits then HIPAA portability regulations may apply. If applicable, Members must refer to the health Policy for the appropriate HIPAA portability guidelines.

MEMBERSHIP APPLICATION

The Corporation will only accept a Membership Application submitted by the Member Institution on behalf of its Students and Dependents. The Corporation will not accept Membership Applications directly from Students or Dependents.

NEGLIGENCE OR MALPRACTICE

The Corporation does not practice medicine. Any treatment, service or Medical Supplies rendered to or supplied to any Member by a Provider is rendered or supplied by such Provider and not by the Corporation. The Corporation is not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in rendering such treatment, service, Medical Supply or medication.

NOTICES

Except as otherwise provided in this Policy, any notice under this Policy may be given by United States registered or certified mail, postage paid, return receipt requested or nationally recognized carrier and addressed:

1. To the Corporation:

   BlueCross BlueShield of South Carolina
   P.O. Box 100300
   Columbia, South Carolina 29202

2. To a Member: To the last known name and address listed for the Student related to such Member on the Membership Application. Members are responsible for notifying the Corporation of any name or address changes within thirty-one (31) days of the change.

3. To the Member Institution or SCSHIC: To the name and address last given to the Corporation. The Member Institution or SCSHIC are responsible for notifying the Corporation of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF THE CORPORATION'S RIGHTS

On occasion, the Corporation may, at its option, choose not to enforce all of the terms and conditions of this Policy. Such a decision does not mean the Corporation waives or gives up any rights under this Policy in the future.

REPLACEMENT COVERAGE

If this Policy replaced the Member Institution's prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered on the Member Institution's Effective Date of this Policy, provided such persons are enrolled for coverage as stated in Article II.

RIGHT OF RECOVERY

If payment for claims exceeds the amount for which the Member is eligible under any benefit provision or rider of the Policy, EyeMed has the right to recover the excess of such payment from the Provider or the Student.

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Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, 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 1-800-832-9686 (TTY: 711) or speak to your provider.

Español: 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 1-844-396-0183 (TTY: 711) o hable con su proveedor. (Spanish)

中文: 注意：如果您說[中文]，我們可以為您提供免費語言援助服務，也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-844-396-0188（TTY：711）或與您的提供者討論。(Chinese)

Tiếng Việt: LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ bổ sung phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi 1-844-389-4838 (TTY: 711) hoặc trao đổi với nhà cung cấp dịch vụ của quý vị. (Vietnamese)

РУССКИЙ: ВНИМАНИЕ! Если вы говорите на русском языке, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-844-389-4840 (TTY: 711) или обратитесь к своему поставщику услуг. (Russian)

Tagalog: PAALALA: Kung nagsasalita ka ng Tagalog, available ang mga libreng serbisyo ng tulong sa wika para sa iyo. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-844-389-4839 (TTY: 711) o makipag-usap sa iyong provider. (Tagalog)

Português do Brasil: ATENÇÃO: Se você fala português, há serviços gratuitos de assistência linguística disponíveis para você. Assistência e serviços auxiliares próprios para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-844-396-0182 (TTY: 711) ou fale com seu provedor. (Portuguese)

Français : NOTE : Si vous parlez français, des services gratuits d'assistance linguistique sont à votre disposition. Des aides et des services auxiliaires appropriés pouvant fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-844-396-0190 (TTY : 711) ou adressez-vous à votre prestataire. (French)

ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-844-641-2898 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. (Gujarati)

Deutsch: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie unter 1-844-396-0191 (TTY: 711) an oder sprechen Sie mit Ihrem Anbieter. (German)

한국어: 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-844-396-0187(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오. (Korean)

العربية: 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 1-844-396-0189 (خدمة الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة. (Arabic)

Українська мова: УВАГА! Якщо ви розмовляєте українською мовою, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби й послуги для надання інформації в доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1- 844-641-2897 (TTY: 711) або зверніться до свого постачальника. (Ukrainian)

日本語: 注: 日本語を希望する場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰でも利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-844-396-0185（TTY: 711）までお電話ください。または、ご利用の事業者にお問い合わせください。 (Japanese)

ไทย: โปรดทราบ: หากคุณพูดภาษา ไทย เรามีบริการความช่วยเหลือด้านแปลภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อที่ 1-844-641-2896 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ (Thai)

ລາວ: ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-844-641-2895 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. (Lao)

हिंदी : 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। 1-844-641-2894 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें। (Hindi)

Diné SHOOH: Diné bee y1ni[ti'gogo, saad bee an1'awo' bee 1ka'an7da'awo'7t'11 jiik'eh n1 h0l=. Bee ahi[hane'go bee nida'anish7 t'11 1kodaat'4h7g77 d00 bee 1ka'an7da'wo'7 1ko bee baa hane'7 bee hadadilyaa bich'8' ahoot'i'7g77 47 t'11 jiik'eh h0l=. Kohj8' 1-844-516-6328 (TTY: 711) hod7ilnih doodago nika'an1lwo'7 bich'8' hanidziih. (Navajo)

Kiswahili MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-844-465-1726 (TTY: 711) au zungumza na mtoa huduma wako. (Swahili)

አማርኛ ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-844-465-1592 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ። (Amharic)

Soomaali FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-844-465-1724 (TTY: 711) ama la hadal bixiyahaaga. (Somali)

ILOCANO PANANGIKASO: No agsasaoka iti Ilocano, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-akses a pormat. Awagan ti 1-800-832-9686 (TTY: 711) wenno makisarita iti mangipapaay kenka. (Ilocano)

नेपाली सावधान: यदि तपाईंनेपाली भाषा बोल्नुहुन्छ भनेतपाईंका लादि दन:शुल्क भादषक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रिान ननउपयुक्त सहायता र सेवाहरू पदन दनि:शुल्क उपलब्ध छन्। 1-844-465-1722 (TTY: 711) मा फोन नुनहोस्वा आफ्नो प्रियकसुँ कु रा नुनहोस्। (Nepali)

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'1-844-396-0184 (TTY: 711) o parla con il tuo fornitore. (Italian)

বাংলা

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 1-844-465-1713 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন। (Bengali)

Kreyòl Ayisyen ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-844-465-1715 (TTY: 711) oswa pale avèk founisè w la. (Haitian Creole)

POLSKI 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 1-844-396-0186 (TTY: 711) lub porozmawiaj ze swoim dostawcą. (Polish)

తెలుగు

సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-800-832-9686 (TTY: 711)కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి. (Telugu)

Lus Hmoob

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-844-465-1717 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob. (Hmong)

ਪੰਜਾਬੀ

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-844-465-1723 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ। (Punjabi)

ភាសាខ្មែរសូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ *ភាសាខ្មែរ* សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលធ្វើការជួយដ៏សមរម្យ ក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរស័ព្ទទៅ 1-844-465-1721 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។ (Khmer)

فارسي

توجه: اگر فارسی صحبت می‌کنید، خدمات رایگان پشتیبانی زبان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات جانبی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-844-398-6233 (تلەتایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید. (Farsi)

اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے مفت لسانی اعانت کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 1-844-465-1725 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔ (Urdu)

אידיש

אכטונג: אויב איר רעדט אידיש, אומזיסטע שפראך הילף סערוויסעס זענען אוועילעבל פאר אייך. פאסיגע אוקזילירי הילף און סערוויסעס צוצושטעלן אינפארמאציע אין צוטריטליכע פארמאטן זענען אויך אוועילעבל פריי פון אפצאל. רופן 1-833-584-1829 (TTY: 711) אדער רעדט מיט אייער פראווייזער. (Yiddish)

Deitsch

WICHDICH: Wann du Deitsch schwetzscht, kenne mer dich Schprooch-Hilf griege. Mir kenne dich aa differnti Sadde Hilf griege, wasewwer as brauchscht fer Information griege, unni as es dich ennich eppes koschde zellt. Call 1-833-584-1829 (TTY: 711) uff odder schwetz mit dei Provider. (Pennsylvania Dutch)

Ελληνικά

ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-844-465-1714 (TTY: 711) ή απευθυνθείτε στον πάροχό σας. (Greek)

Oromoo

Afaan Oromoo HUBACHIISA: Yoo Afaan Oromoo dubbattan ta'e, tajaajilloota gargaarsa afaanii bilisaan isiniif ni kennama. Gargaarsoonni fi tajaajilloonni sirrii ta'an namoota dhagahuufi arguun isaan rakkisuuf odeeffannoo dhangii dhaqqabamaa ta'een kennuunis bilisaan niargamu. Gara 1-800-832-9686 (TTY: 711) tti bilbilaa yookiin qopheessaa keessan haasofsiisaa. (Oromo)

Gagana Samoa

FAAALIGA: Afai e te tautala i le Gagana Samoa, o loo maua fua auaunaga lagolago mo gagana. O le a maua fua fo'i mea faalogo, isi faiga tau fesoasoani ma auaunaga talafeagai e tuuina mai ai faamatalaga i auala faigofie ona maua. Vili le 1-800-832-9686 (TTY: 711) pe talanoa i lau fai auaunaga. (Samoan)



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