



# University of New Mexico Student Vision Insurance Plan 2025-2026

Underwritten by: Blue Cross and Blue Shield of New Mexico

Please review to understand your coverage.

Account Number: 190482



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.

**THE COVERED PERSON SHALL HAVE THE RIGHT TO RETURN THIS POLICY WITHIN 30 DAYS OF ITS DELIVERY, AND TO HAVE ANY REQUIRED PREMIUMS REFUNDED, IF AFTER EXAMINATION OF THIS POLICY THE COVERED PERSON IS NOT SATISFIED FOR ANY REASON, PROVIDED NO CLAIM HAS BEEN PAID.**

**Blue Cross and Blue Shield of New Mexico**  
(Herein called BCBSNM, We, Us, Our)

Has issued this

**Student Vision Policy**  
to  
**University of New Mexico**

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

Janice Torrez,  
President, Blue Cross and Blue Shield of New Mexico

**THE VISION SCHEDULE OF BENEFITS ENCLOSED WITH THIS POLICY INDICATES BENEFIT PERCENTAGES, DEDUCTIBLES, MAXIMUMS, AND OTHER BENEFIT AND PAYMENT INFORMATION THAT APPLIES TO THIS POLICY.**

**NOTICE TO CONSUMER: THIS IS A LIMITED BENEFITS HEALTH POLICY. THE BENEFITS PROVIDED ARE SUPPLEMENTAL TO, AND NOT A SUBSTITUTE FOR, MAJOR MEDICAL COVERAGE, EVEN IN CONJUNCTION WITH OTHER LIMITED HEALTH POLICIES. TO APPLY FOR AN INDIVIDUAL OR SMALL-GROUP MAJOR MEDICAL POLICY, PLEASE VISIT THE WEBSITE OF THE NEW MEXICO HEALTH INSURANCE EXCHANGE AT [WWW.BEWELLMN.COM](http://WWW.BEWELLMN.COM) OR CALL 1-833-862-3935 (TTY: 711).**

AcademicBlue is offered by Blue Cross and Blue Shield of New Mexico, 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 NEW MEXICO**

BCBSNM 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 BCBSNM Student Vision Policy. BCBSNM has also contracted with First American Administrators (FAA) to provide Claims administration services to Covered Persons enrolled in this BCBSNM Student Vision Policy. The relationship between BCBSNM, 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 BCBSNM.

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

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# SCHEDULE OF BENEFITS

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

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

Vision Care Benefits	EyeMed Provider	Non-Contracting Provider Reimbursement*
Vision Examination	\$10 Copay	Up to \$30
<b>Frames:</b> 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> (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> (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 – Tier 1	\$57 Copay
Premium Anti-Reflective Coating – Tier 2	\$68 Copay
Premium Anti-Reflective Coating – Tier 3	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> 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 under this Student Vision Policy. If after reading it, You still have questions, please contact EyeMed Customer Service for BCBSNM 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 Classes 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 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: Students and their spouse (including Domestic Partner) are eligible for coverage under this Policy. Dependent children are not eligible for coverage.

**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, religion, or political affiliation. Coverage does not require documentation certifying a COVID-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving Benefits. Variations in the administration, processes or Benefits of this Policy that are based on clinically indicated, reasonable management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.**

## **EFFECTIVE DATE OF COVERAGE**

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

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

After the time periods described above, the Student 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.

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 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 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 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) means a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities. This 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.

If a Vision Examination indicates that corrective lenses are necessary, each Covered Person is entitled to necessary frames and lenses, including coverage for single vision, bifocal, trifocal, and lenticular as medically necessary. Medically necessary contact lenses are covered in full, and elective lenses are covered. Please see your Schedule of Benefits for more details.

## EyeMed CONTRACTING PROVIDER

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

Visit EyeMed's website at [www.eyemedvisioncare.com/bcbsnmind.com](http://www.eyemedvisioncare.com/bcbsnmind.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/mailing 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; or
- 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.

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;
- A Covered Person ceases to maintain eligibility; 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. BCBSNM (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. If you require emergency vision care and cannot reach an EyeMed Contracting Provider, you may submit a claim form pursuant to #2 and #3 below. (An emergency will be judged by the perspective of a reasonable person in the same or similar circumstance.)
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**

## **MEDICAID**

Payment of Benefits for Covered Persons eligible for Medicaid is made to the appropriate state agency or to the Provider when required by law.

## **PAYMENT IN ERROR**

If BCBSNM makes an erroneous Benefit payment, You or the ineligible person may be required to refund the amount paid in error. BCBSNM reserves the right to correct payments made in error by offsetting the amount paid in error against new Claims. BCBSNM 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 BCBSNM at the address noted below. You may also include written comments or supporting documentation.

BCBSNM 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 BCBSNM's receipt of Your Complaint. Upon final resolution, BCBSNM 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 BCBSNM 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 Vision Care Provider that will assist BCBSNM 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 New Mexico**  
**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 BCBSNM.com

For an Appeal or filing a Complaint to the Consumers Assistance Bureau of the Office of Superintendent of Insurance, send your request to:

**Office of Superintendent of Insurance**  
**Consumers Assistance Bureau**  
**P.O. Box 1689**  
**Santa Fe, NM 87504-1689**  
**1-833-415-0566**

**<https://www.osi.state.nm.us/pages/bureaus/consumer/resources/consumer-assistance>**

# **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, 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.

## **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 New Mexico, 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 New Mexico 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 New Mexico offers to, You, if You do not reside in the Blue Cross and Blue Shield of New Mexico service area, Blue Cross and Blue Shield of New Mexico 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 New Mexico 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 BCBSNM. BCBSNM 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 BCBSNM use the Blue Cross and Blue Shield service marks in the State of New Mexico. BCBSNM 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 BCBSNM. No person, entity, or organization other than BCBSNM shall be held accountable or liable to the Institution for any of its obligations whatsoever on the on the part of BCBSNM 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 BCBSNM 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 (BCBSNM) 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 BCBSNM to be limited or harmed by any acts or failure to act on the part of any Student.

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 New Mexico 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**

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

- Receive substantial payments from Providers or suppliers with respect to goods, supplies and services furnished to all such persons for which BCBSNM 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 BCBSNM contracts with them.

### **SEVERABILITY**

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

### **TIME OF PAYMENT OF CLAIMS**

Benefits payable under this Student Vision Policy for any loss will be paid as soon as reasonably possible following receipt of due written Proof of Loss.

# **PREMIUMS AND REINSTATEMENT PROVISIONS**

## **PAYMENT OF PREMIUM**

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

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

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

## **GRACE PERIOD**

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 default is made in the stipulated Premium payments for this Policy, the subsequent acceptance of such Premium payments by BCBSNM shall reinstate this Policy. For purposes of reinstatement, mere receipt and/or negotiation of a late Premium shall not constitute acceptance. The reinstated Policy shall not cover loss due to covered vision expenses incurred after the date of termination. In all other respects, the Covered Person shall have the same rights under this Policy as he had immediately before the due date of the defaulted Premiums, including his right to apply the period of time this Policy was in effect immediately before the due date of the defaulted Premiums toward satisfaction of any Benefits, subject to any provisions endorsed hereon or attached hereto in connection with the Reinstatement. Any Premium accepted in connection with a Reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than 60 days prior to the date of Reinstatement.

# **PAYMENT OF BENEFITS; PROVIDER RELATIONSHIP**

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

All Benefit payments may be made by BCBSNM directly to any Provider furnishing the Covered Services for which such payment is due, and BCBSNM is authorized by You to make such payments directly to such Providers. However, BCBSNM 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 BCBSNM's Benefit payment. You may be required to submit a copy of the assignment of Benefits to BCBSNM.

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

## COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies to this Benefit Program when a Student or a Student's covered Dependent has health care coverage under more than one Benefit Program.

The order of Benefit determination rules should be looked at first. Those rules determine whether the Benefits of this Benefit Program are determined before or after those of another Benefit Program. The Benefits of this Benefit Program:

1. Shall not be reduced when, under the order of Benefit determination rules, this Benefit Program determines its Benefits before another Benefit Program; but
2. May be reduced when, under the order of Benefits determination rules, another Benefit Program determines its Benefits first. This reduction is described below in *When this Benefit Program is a Secondary Program*.

In addition to the Definitions Section of this Policy, the following definitions apply to this section.

**ALLOWABLE EXPENSE** means a Covered Service, when the Covered Service is covered at least in part by one or more Benefit Program covering the person for whom the Claim is made.

When a Benefit Program provides Benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a Benefit paid.

**BENEFIT PROGRAM** means any of the following which provides Benefits or services for, or because of, vision care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage; or
2. Coverage under a governmental Policy, or coverage required or provided by law. This does not include a state Policy under Medicaid (Title XIX of the Social Security Act).

Each Policy or other arrangement under (i) or (ii) above is a separate Benefit program. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate program.

**CLAIM DETERMINATION PERIOD** means the Benefit Period. However, it does not include any part of the Benefit Period during which a person has no coverage under this Benefit Program, or any part of the Benefit Period before the date this COB provision or a similar provision takes effect.

**PRIMARY PROGRAM or SECONDARY PROGRAM** means the order of payment responsibility as determined by the order of Benefit determination rules.

When this Benefit Program is the Primary Program, its Benefits are determined before those of the other Benefit Program and without considering the other program's benefits.

When this Benefit Program is a Secondary Program, its Benefits are determined after those of the other Benefit Program and may be reduced because of the other program's Benefits.

When there are more than two Benefit Programs covering the person, this Benefit Program may be a Primary Program as to one or more other programs and may be a Secondary Program as to a different program or programs.

### ORDER OF BENEFIT DETERMINATION

When there is a basis for a Claim under this Benefit Program and another Benefit Program, this Benefit Program is a Secondary Program which has its Benefits determined after those of the other program, unless:

1. The other Benefit Program has rules coordinating its Benefits with those of this Benefit Program; and
2. Both those rules and this Benefit Program's rules, described below, require that this Benefit Program's Benefits be determined before those of the other Benefit Program.

This Benefit Program determines its order of Benefit payments using the first of the following rules which applies.

## **1. Child**

If the Covered Person who receives care is a child, the longest covered parent's coverage pays first. The Benefits of the Benefit Program which covers the person as a Student (that is, other than a Dependent) are determined before those of the Benefit Program which covers the person as a Dependent, except that, if the person is also a Medicare beneficiary, Medicare is:

- a. Secondary to the Benefit Program covering the person as a Dependent; and
- b. Primary to the Benefit Program covering the person as other than a Dependent, for example a retired employee.

## **2. Dependent Child if Parents not Separated or Divorced**

Except as stated in rule 3 below, when this Benefit Program and another Benefit Program cover the same child as a Dependent of different persons, called "parents:"

- a. The Benefits of the program of the parent whose birthday (month and day) falls earlier in a calendar year are determined before those of the program of the parent whose birthday falls later in that year; but
- b. If both parents have the same birthday, the Benefits of the program which covered the parents longer are determined before those of the program which covered the other parent for a shorter period of time.

However, if the other Benefit Program does not have this birthday-type rule, but instead has a rule based upon gender of the parent, and if, as a result, the Benefit Programs do not agree on the order of Benefits, the rule in the other Benefit Program will determine the order of Benefits.

## **3. Dependent Child if Parents Separated or Divorced**

If two or more Benefit Programs cover a person as a Dependent Child of divorced or separate parents, Benefits for the child are determined in this order:

- a. First, the program of the parent with custody of the child;
- b. Then, the program of the spouse of the parent with the custody of the child; and
- c. Finally, the program of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the Benefits of the program of that parent has actual knowledge of those terms, the Benefits of that program are determined first. The program of the other parent shall be the Secondary Program. This paragraph does not apply with respect to any Claim Determination Period or Benefit Program year during which any Benefits are actually paid or provided before the entity has that actual knowledge. It is the obligation of the person claiming Benefits to notify Blue Cross and Blue Shield and, upon its request, to provide a copy of the court decree.

## **4. Dependent Child if Parents Share Joint Custody**

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Benefit Programs covering the child shall follow the order of Benefit determination rules outlined in 2 above.

## **5. Active or Inactive Employee**

The Benefits of a Benefit Program which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Benefit Program which covered that person as a laid off or retired employee (or as that employee's Dependent). If the other Benefit Program does not have this rule, and if, as a result, the Benefit Programs do not agree on the order of Benefits, this rule is ignored.

## **6. Continuation Coverage**

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Benefit Program, the following shall be the order of Benefit determination:

- a. First, the Benefits of a Benefit Program covering the person as an employee, member, or subscriber (or as that person's Dependent); and

- b. Second, the Benefits under the continuation coverage.

## **7. Length of Coverage**

If none of the above rules determines the order of Benefits, the Benefits of the Benefit Program which covered an employee, member or subscriber longer are determined before those of the Benefit Program which covered that person for the shorter term.

### **WHEN THIS BENEFIT PROGRAM IS A SECONDARY PROGRAM**

In the event this Benefit Program is a Secondary Program as to one or more other Benefit Programs, the Benefits of this Benefit Program may be reduced.

The Benefits of this Benefit Program will be reduced when the sum of:

1. The Benefits that would be payable for the Allowable Expenses under this Benefit Program in the absence of this COB provision; and
2. The Benefits that would be payable for the Allowable Expenses under the other Benefit Programs, in the absence of provisions with a purpose like that of this COB provision, whether or not a Claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the Benefits of this Benefit Program will be reduced so that they and the Benefits payable under the other Benefit Programs do not total more than those Allowable Expenses.

When the Benefits of this Benefit Program are reduced as described above, each Benefit is reduced in proportion. It is then charged against any applicable Benefit limit of this Benefit Program.

### **RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

Certain facts are needed to apply these COB rules. Blue Cross and Blue Shield has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Blue Cross and Blue Shield need not tell, or obtain the consent of, any person to do this. Each person claiming Benefits under this Benefit Program must give Blue Cross and Blue Shield any facts necessary to pay the Claim.

### **FACILITY OF PAYMENT**

A payment made under another Benefit Program may include an amount which should have been paid under this Benefit Program. If it does, Blue Cross and Blue Shield may pay that amount to the organization which made that payment. That amount will then be treated as though it were a Benefit paid under this Benefit Program. Blue Cross and Blue Shield will not have to pay that amount again. The term *payment made* includes providing Benefits in the form of services, in which case *payment made* means reasonable cash value of the Benefits provided in the form of services.

### **RIGHT OF RECOVERY**

If the amount of payments made by Blue Cross and Blue Shield is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

The *amount of payments made* includes the reasonable cash value of any Benefits provided in the form of services.

# 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 Student Vision Policy.

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

**BCBSNM, We, Us, or Our** means Blue Cross and Blue Shield of New Mexico, 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 BCBSNM 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 paid for Covered Services or Covered Materials.

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

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

**Domestic Partner** means a person with whom You have entered into a Domestic Partnership with.

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

- A Student and his/her Domestic Partner have lived together for at least 6 months;
- Neither a Student or his/her Domestic Partner is married to anyone else or has another Domestic Partnership;
- A Student's Domestic Partner is at least 18 years of age and mentally competent to consent to contract;
- A Student's Domestic Partner resides with him/her and intends to do so indefinitely;
- A Student and his/her Domestic Partner have an exclusive mutual commitment similar to marriage; and
- A Student and his/her Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.

**Effective Date of Coverage** is 12:01 a.m. of the date on which a 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 may enroll for coverage under this Student Vision Policy.

**Policy** means this Policy issued by Blue Cross and Blue Shield of New Mexico 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** 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, optometrist, or therapeutic optometrist operating within the scope of his or her license, or a dispensing optician.

**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, or other physician who has completed a residency in ophthalmology, 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, or other abnormalities 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 covered under this Student Vision Policy.

### Health care coverage is important for everyone.

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

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

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

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

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

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

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

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

Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجاناً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો.
हिंद	ननि:शुल्क भाषा या सिंचार स ायता प्राप्त करने के लिए, कृपया में 855-710-6984 पर कॉि करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984 번으로 전화해 주세요.
Navajo	Nin1: Doo bilag1ana bizaad dinit's'1'g00, sh1 ata' hodooni n7n7zingo, t'11j77k'eh bee n1haz'1. 1-866-560-4042 j8' hod7ilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.