Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

BLUE VISION GROUP BENEFITS CERTIFICATE

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This contract is between you and Blue Cross Blue Shield of Michigan. Because we are an independent corporation licensed by the Blue Cross and Blue Shield Association - an association of independent Blue Cross and Blue Shield plans - we are allowed to use the Blue Cross and Blue Shield names and service marks in the state of Michigan. However, we are not an agent of BCBSA and, by accepting this contract, you agree that you made this contract based only on what you were told by BCBSM or its agents. Only BCBSM has an obligation to provide benefits under this certificate and no other obligations are created or implied by this language.

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Dear Subscriber:

We are pleased you have selected Blue Vision for your vision care coverage. Your coverage provides many benefits for you and your eligible dependents. These benefits are described in this book, which is your **certificate**.

- Your certificate, your signed application and your BCBSM identification card are your contract with us.
- You may also have riders. Riders make changes to your certificate and are an important part of your coverage. When you receive riders, keep them with this book.

This certificate will help you understand your benefits and each of our responsibilities **before** you require vision services. Please read it carefully.

Administration of the plan is shared between Blue Cross Blue Shield of Michigan and Vision Service Plan. If you have any questions about your coverage, call VSP at the telephone number in the "How to Reach VSP" section of this book.

Thank you for choosing Blue Cross Blue Shield of Michigan. Every Blue Cross Blue Shield and VSP employee is dedicated to giving you the finest service. We look forward to serving you for many years.

Sincerely,

Daniel J. Loepp
President and Chief Executive Officer
Blue Cross Blue Shield of Michigan

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About Your Certificate

This certificate is arranged to help you locate information easily. You will find:

- **A Table of Contents** – for quick reference
- **Information About Your Contract**
- **What You Must Pay**
- **Coverage for Vision Care Services**
- **Vision Care Services Not Covered**
- **General Conditions of Your Contract**
- **Definitions**-- explanations of the terms used in your certificate
- **Additional Information You Need to Know**
- **How to Reach VSP**
- **Index**

This certificate provides you with the information you need to get the most from your vision care coverage.

If you have any questions about your vision coverage, please call VSP Customer Service department at **1-800-877-7195.**

Please have your ID card with your group and contract numbers ready when you call.

Your certificate refers to you as the **subscriber** because the contract is in your name.

The term **patient** refers to either you or one of your eligible dependents when you receive vision care coverage. Your eligible dependents are those listed on your application.

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Section 1: Information About Your Contract

This section provides answers to general questions you may have about your contract. Topics include:

- **ELIGIBILITY**
  - Who is Eligible for Coverage
  - Who is Eligible to Receive Benefits
  - Changing Your Coverage
  - When You Can Enroll
  - When Your Benefits Begin
- **TERMINATION**
  - How to Terminate Your Coverage
  - How We Terminate Your Coverage
  - Rescission
- **CONTINUATION OF BENEFITS (COBRA)**

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ELIGIBILITY

Who is Eligible for Coverage

You will need to complete an application for coverage. BCBSM will review your application to determine if you, your spouse (this does not include a person who marries a member who has coverage as a surviving spouse) and your dependents are eligible for coverage. We will base our decision on the terms of your benefit plan. The terms include this certificate and any underwriting policies that are in effect at the time of your application.

If you, your group or someone applying for coverage on your behalf commits fraud or intentionally misrepresents a material fact in completing the application, your coverage may be rescinded as explained on Page 7, under Rescission.

Who Is Eligible to Receive Benefits

Children listed on your contract are covered through the end of the calendar year in which they turn age 26, if:

- You continue to be covered under this certificate and
- The children are related to you by:
  - Birth
  - Marriage
  - Legal adoption or
  - Legal guardianship

Your child's spouse and your grandchildren are not covered under this certificate.

<u>Disabled, unmarried children</u>

Disabled, unmarried children may remain covered after they turn age 26 if all of the following apply:

- They cannot support themselves due to a diagnosis of:
  - A physical disability or
  - A developmental disability

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Eligibility (continued)

Disabled, unmarried children (continued)

- They are dependent on you for support and maintenance.

Your employer must send us a physician's certification proving the child's disability. We must receive it by 31 days after the end of the year of the child's 26th birthday. We will decide if the child meets the requirements.

Coverage may be available to dependent children through a BCBSM individual plan. COBRA coverage (if applicable) may also be available.

Divorced spouses are no longer eligible for coverage on the subscriber's contract.

Changing Your Coverage

You may change your coverage only during the annual open enrollment period or at other times of the year as established by federal law.

You may change who may receive benefits under your current coverage if there is a qualifying event, (please see the definition of "qualifying event" in the Definitions section), including, but not limited to:

- A Birth
- Adoption
- Marriage
- Divorce
- Death of a member
- Start of military service

There may be changes in your family while you have coverage under this certificate. If there is a change in your family, you must notify your group. Your group must notify BCBSM within 30 days of the requested termination date. Your coverage will then be terminated on the requested date and all benefits under this certificate will end.

We must receive notice from your group within 31 days of the requested date to add a dependent or spouse. Contract changes take effect as of the date of the event.

If a dependent cannot be covered by your contract anymore, he or she may be able to get his or her own contract.

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Eligibility (continued)

Changing Your Coverage (continued)

If a member on your contract dies, please notify us, and your rate will be adjusted as of the date of death.

When You Can Enroll

- During the annual open enrollment period
- At other times of the year, as allowed by federal law

When Your Benefits Begin

Covered benefits and services are available on the effective date of your contract.

TERMINATION

How to Terminate Your Coverage

Send your written request to terminate coverage to your employer or group. We must receive it from your employer or group within 30 days of the requested termination date. Your coverage will then be terminated on the requested date and all benefits under this certificate will end.

How We Terminate Your Coverage

We may terminate this vision coverage if:

- Your group does not qualify for coverage under this certificate.
- You no longer qualify as a member or dependent
- You no longer qualify to be a member of your group
- Your group does not pay its bill on time
- You are serving a criminal sentence for defrauding BCBSM
- We no longer offer this coverage
- Your group changes to a non-BCBSM health plan

How We Terminate Your Coverage (continued)

- You **misuse** your coverage

  Misuse includes illegal or improper use of your coverage such as:

  – Allowing an ineligible person to use your coverage
  – Requesting payment for services you did not receive

- You fail to repay BCBSM for payments we made for services that were not a benefit under this certificate, subject to your rights under the appeal process

- You are satisfying a civil judgment in a case involving BCBSM

- You are repaying BCBSM funds you received illegally

Your coverage ends on the last day covered by the last premium payment. If a child is no longer eligible for coverage because of age, coverage will end on the last day of the year in which the child turns 26.

Rescission

We will rescind your coverage if you, your group or someone seeking coverage on your behalf has:

- Performed an act, practice, or omission that constitutes fraud, or

- Made an intentional misrepresentation of material fact to BCBSM or another party, which results in you or a dependent obtaining or retaining coverage with BCBSM, or the payment of claims under this or another BCBSM certificate.

We may rescind your coverage back to the effective date of your contract. If we do, we will provide you with 30 days' notice. Once we notify you that we are rescinding your coverage, we may hold or reject claims during this 30-day period. You will have to repay BCBSM for its payment for any services you received.

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CONTINUATION OF BENEFITS

Consolidated Omnibus Budget Reconciliation Act (COBRA)

A federal law that may allow you to temporarily keep your health coverage after:

- Your employment ends,
- You lose coverage as a dependent of the covered employee, or
- Another qualifying event.

If you elect COBRA coverage, you pay 100 percent of the premiums, including the share the employer used to pay for you, plus a small administrative fee.

COBRA most employers with 20 or more employees. It allows you to continue your employer group coverage if you lose it due to a qualifying event such as being laid off or fired. See Page 28 to read about "Qualifying Events". Your employer must send you a COBRA notice. You have 60 days to choose to continue your coverage. The deadline is 60 days after you lose coverage or 60 days after your employer sends you the notice, whichever is later. If you choose to keep the group coverage you must pay for it. The periods of time you may keep it are:

- 18 months of coverage for an employee who is terminated, other than for gross misconduct, or whose hours are reduced
- 29 months of coverage for all qualified beneficiaries if one member is determined by the Social Security Administration to be disabled at the time of the qualifying event or within 60 days thereafter
- 36 months of coverage for qualified beneficiaries in case of the death of the employee, divorce, legal separation, loss of dependency status, or employee entitlement to Medicare

COBRA coverage can be terminated because:

- The 18, 29 or 36 months of COBRA coverage end
- The required premium is not paid on time
- The employer terminates its group health plan
- The qualified beneficiary is entitled to Medicare coverage
- The qualified beneficiary gets coverage under a group dental plan. If this plan has limits on pre-existing conditions that apply to the beneficiary, then COBRA cannot be terminated.

Please contact your employer for more details about COBRA.

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Individual Coverage

If you choose not to enroll in COBRA, or if your COBRA coverage period ends, coverage may be available through a BCBSM individual plan. Contact BCBSM Customer Service for information about what plan best meets your needs.

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Section 2: What You Must Pay

This section explains what you must pay for covered vision services.

The basic copayments you must pay each benefit period are listed in the chart below and explained in more detail in the pages that follow. These are standard amounts associated with this certificate. The amounts for which you are responsible may differ depending on what riders your plan has.

Cost-Sharing Chart	
	In-network and Out-of-network
Copayment	**$5** per eye exam **$10** per pair of prescription glasses or medically necessary contact lenses

Copayment Requirements

You are required to pay copayments on select covered services.

Routine Eye Examinations

- Your copayment is $5.

Standard Lenses and Frames

- Your copayment is $10. You pay one copayment for both lenses and frames.

Contact Lenses

- Your copayment is $10 for medically necessary contact lenses. The criteria used to decide if contact lenses are medically necessary are on Page 14.
- You do not have a copayment for prescribed contact lenses that are not medically necessary. However, you must pay the difference between our approved amount and the amount charged by your provider.

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In-Network Providers

After your copayment, the following services are fully covered (within plan limitations) when you get them from an in-network provider:

- Routine eye examinations
- Standard lenses and frames
- Medically necessary contact lenses

Contacts that are not medically necessary are covered up to the benefit maximum

If the lenses and frames you select are more expensive than the standard lenses and frames described in Section 3, you are responsible for the difference between the maximum allowance and the amount charged by the provider.

An in-network provider **may bill you** when:

- You use a service not covered by your contract or
- We deny a claim from an in-network provider submitted more than 180 days after the date of service because you did not supply the needed information to the provider or to VSP.

Out-of-Network Providers

We pay our approved amount, minus your copayment, for exams, lenses and frames and prescribed medically necessary contact lenses obtained from out-of-network providers. For prescribed, non-medically necessary contact lenses we pay our approved amount. You do not have a copayment for these lenses. The amount billed by an out-of-network provider may be more than our approved amount.

You are responsible for the difference between our approved amount and the amount charged by the out-of-network provider. The out-of-network approved amount we pay for vision care services is reviewed and adjusted annually. See Section 8 for information on how to contact VSP to determine the current amount.

You should expect to pay charges to an out-of-network provider at the time you receive the services. You should then submit a claim. If it is approved, payment will be sent to you. See **Section 8: How to Reach VSP** for the address to send claims.

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Section 3: Coverage for Vision Care Services

This section describes the covered vision services we pay for and the extent to which they are covered.

Frequency

We pay for:

- One eye exam every 12 months
- One pair of lenses, or prescribed contact lenses once every 24 months
- One pair of frames once every 24 months

Eye Exam

We pay for an eye exam by an ophthalmologist or optometrist. The exam must include the following:

- History
- Testing of visual acuity
- External exams of the eye
- Binocular measure
- Ophthalmoscopic examinations
- Tonometry (test for glaucoma) when indicated
- Medication for dilating the pupils and desensitizing the eyes for Tonometry, if necessary
- Summary of findings

Lenses

We pay for standard lenses when prescribed and dispensed by an ophthalmologist or optometrist.

- Lenses may be molded or ground, glass or plastic.
- Lenses must be equal in quality to the first-quality lens series made by American Optical, Bausch & Lomb or Tillyer and Univis.
- The lens blank must meet Z80.1 or Z80.2 standards of the American National Standards Institute.

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Lenses (continued)

- The lenses may be colorless or have rose tints #1 or #2 if therapeutically necessary. The provider may charge you for additional tinting other than for necessary rose tints #1 or #2.
- The lens blank of a standard lens must not exceed 60 mm in diameter. The provider may charge you for the difference in cost between standard and oversize lenses.
- If only one lens is needed, we pay half the amount we pay per pair.

We pay for the following special lenses:

- Myodisc
- Lenticular myodisc
- Lenticular aspheric myodisc
- Aphakic
- Lenticular aphakic
- Lenticular aspheric aphakic
- Polycarbonate lenses for children through 25 years of age

We do not pay for aphakic lenses for aphakia (lack of natural lens). These may be covered by your hospital-medical-surgical plan.

We pay for prism, slab-off prism and special base curve lenses when medically necessary.

Frames

We pay for standard frames. If you select more expensive frames, the provider may charge you the difference between our approved amount and the provider's charge for the more expensive frames.

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Contact Lenses

Suitability Exam

A contact lens suitability exam determines whether you can wear contact lenses. The fee for this exam is included in the allowance for the contact lenses. The exam may include:

- Biomicroscopic evaluation
- Lid evaluation
- Ophthalmoscopy
- Tear test
- Pupil evaluation
- Fluorescein evaluation
- Cornea evaluation
- Lens tolerance tests

We pay for medically necessary contact lenses. Medically necessary contacts require prior authorization from VSP. Contact lenses are considered medically necessary if:

- They are the only way to correct vision to 20/70 in the better eye or
- They are the only effective treatment to correct keratoconus, irregular astigmatism or irregular corneal curvature

If prescription contact lenses are not needed for the above reasons, our approved amount for lenses that are not medically necessary is less. You pay the difference between this amount and the provider's charge.

If only one lens is needed, we pay half the amount we pay per pair.

We do not pay for cosmetic contact lenses that do not improve vision.

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Section 4: Vision Care Services Not Covered

The services listed in this section are in addition to all other services we do not cover, which are stated elsewhere in this certificate.

Exclusions

The following services are **not** covered under this certificate unless you have a rider that adds coverage for them. You are responsible for paying the charges for these services:

- Additional charges for:
  - Antireflective lenses
  - Blended lenses
  - Coating/laminating of a lens or lenses
  - Cosmetic lenses/processes
  - Lenses tinted darker than rose tint #2 (such as sunglasses)
  - Oversize lenses (61 mm and larger)
  - Photochromic lenses
  - Progressive/Multifocal lenses
  - Two pair of glasses instead of bifocals
- Medical-surgical treatment
- Medications administered during any service except an eye exam
- Services or eyewear ordered before coverage began
- Services not prescribed by an ophthalmologist or optometrist
- Special services, such as orthoptics, vision training, aniseikonic lenses and Tonography
- Replacement of broken or lost lenses or frames
- Services available at no cost to you or for which no charge would be made in the absence of BCBSM coverage
- Charges for lenses or frames ordered while you were eligible for benefits but delivered more than 60 days after coverage ends
- Charges for completing insurance forms
- Aphakic lenses when the patient lacks a natural lens
- Charges for experimental or poor-quality services
- Medically unnecessary services, glasses or contact lenses

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We do not pay for the following: (continued)

- Experimental or investigational services:

  We do not pay for the following when they have not been scientifically demonstrated to be safe and effective for treatment of the patient's condition:

  - Services
  - Procedures
  - Treatments
  - Devices
  - Drugs
  - Supplies
  - Administrative costs related to experimental treatment or for research management

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Section 5: General Conditions of Your Contract

This section explains the conditions that apply to your certificate. They may make a difference in how, where and when benefits are available to you.

Assignment

Benefits covered under this certificate are for your use only. They cannot be transferred or assigned. Any attempt to assign them will automatically terminate all your rights under this certificate. You cannot assign your right to any payment from us, or for any claim or cause of action against us, to any person, provider, or other insurance company.

We will not pay a provider except under the terms of this certificate.

Changes in Your Address

Your employer or group must notify us of any changes in your address. An enrollment/change of status form should be completed when you change your address.

Changes in Your Family

Your employer must notify us of any changes in your family. Changes include marriage, divorce, birth, death, adoption, or the start of military service.

You must complete an enrollment/change of status form and give it to your employer or group. We must receive notice from your employer within 30 days of when a dependent or spouse is removed from your coverage and within 31 days of when a dependent or spouse is added. Any coverage changes will take effect on the date of the event.

Changes to Your Certificate

BCBSM employees, agents or representatives cannot agree to change or add to the benefits described in this certificate.

- Any changes must be in writing and approved by BCBSM and the Michigan Department of Insurance and Financial Services.
- We may add, limit, delete or clarify benefits in a rider that amends this certificate. If you have riders, keep them with this certificate.

Coordination of Benefits

We coordinate benefits payable under this certificate per Michigan's Coordination of Benefits Act.

Deductibles, Copayments and Coinsurances Paid under Other Certificates

We do not pay any cost-sharing you must pay under any other certificate. An exception is when we must pay them under coordination of benefits requirements.

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Enforceability of Various Provisions

Failure of BCBSM to enforce any of the provisions contained in this contract will not be considered a waiver of those provisions.

Entire Contract; Changes

This certificate, including your riders, if any, is the entire contract of your coverage. No change to this certificate is valid until approved by a BCBSM executive officer. No agent has authority to change this certificate or to waive any of its provisions.

Experimental Treatment

Services That Are Not Payable

We do not pay for:

- Experimental treatment. This includes experimental drugs and devices
- Services, drugs, devices and administrative costs related to experimental treatment
- Costs of research management.

How BCBSM Determines If a Treatment Is Experimental

BCBSM's medical director determines if it is experimental. The director may decide it is experimental if:

- Medical literature or clinical experience cannot say whether it is safe or effective for treatment of any condition, or
- It is shown to be safe and effective treatment for some conditions. However, there is inadequate medical literature or clinical experience to support its use in treating the patient's condition, or
- Medical literature or clinical experience shows the treatment to be unsafe or ineffective for treatment of any condition, or
- There is a written experimental or investigational plan by the attending provider or another provider studying the same treatment, or
- It is being studied in an on-going clinical trial, or
- The treating provider uses a written informed consent that refers to the treatment, as:
  - Experimental or investigational, or
  - Other than conventional or standard treatment.

The medical director may consider other factors.

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Experimental Treatment (continued)

How BCBSM Determines If a Treatment is Experimental (continued)

When available, these sources are considered in deciding if a treatment is experimental under the above criteria:

- Scientific data (e.g., controlled studies in peer-reviewed journals or medical literature)
- Information from the Blue Cross and Blue Shield Association or other local or national bodies
- Information from independent, nongovernmental, technology assessment and medical review organizations
- Information from local and national medical societies, other appropriate societies, organizations, committees or governmental bodies
- Approval, when applicable, by the FDA, the Office of Health Technology Assessment (OHTA) and other government agencies
- Accepted national standards of practice in the medical profession
- Approval by the hospital's or medical center's Institutional Review Board

The medical director may consider other sources.

<u>Services That Are Payable</u>

We do pay for experimental treatment and its related services when **all** of the following are met:

- BCBSM considers the experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for).
- It is covered under your certificate when provided as conventional treatment.
- The services related to the experimental treatment are covered under your certificates when they are related to conventional treatment.

<u>Limitations and Exclusions</u>

- This general condition does not add coverage for services not otherwise covered under your certificate.

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Fraud, Waste, and Abuse

We do not pay for the following:

- Services that are not medically necessary; may cause significant patient harm; or are not appropriate for the patient's documented medical condition;
- Services that are performed by a provider who is sanctioned at the time the service is performed.

Sanctioned providers have been sanctioned by BCBSM, the Office of the Inspector General, the Government Services Agency, the Centers for Medicare and Medicaid Services, or state licensing boards.

BCBSM will notify you if any provider you have received services from during the previous 12 months has been sanctioned. You will have 30 days from the date you are notified to submit claims for services you received prior to the provider being sanctioned. After that 30 days has passed, we will not process claims from that provider.

Genetic Testing

We will not:

- Adjust premiums for this coverage based on genetic information related to you, your spouse or your dependents
- Request or require genetic testing of anyone covered under this certificate
- Collect genetic information from anyone covered under this certificate at any time for underwriting purposes
- Limit coverage based on genetic information related to you, your spouse or your dependents

Grace Period

A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the coverage shall continue in force.

Improper Use of Contract

If you let an ineligible person receive benefits (or try to receive benefits) under this certificate, we may:

- Refuse to pay benefits
- Terminate or cancel your contract
- Begin legal action against you
- Refuse to cover your vision care services at a later date

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Individual Coverage

If you choose not to enroll in Consolidated Omnibus Budget Reconciliation Act [COBRA], or if your COBRA coverage period ends, coverage may be available through a BCBSM individual plan. Contact BCBSM Customer Service for information about what plan best meets your needs.

Notification

When we need to notify you, we mail it to your employer, or your remitting agent. This fulfills our obligation to notify you.

Personal Costs

We will not pay for:

- Transportation and travel, even if recommended by a licensed practitioner, , except as provided in this certificate
- Care, services, supplies or devices that are personal or convenience items
- Charges to complete claim forms

Prior Authorization

Some vision benefits services require prior authorization before you receive them. If you receive those services without first obtaining prior authorization, you may have to pay the bill yourself. We may not pay for it. It is important to make sure that your provider gets the prior authorization before you receive the services.

Release of Information

You agree to let providers release information to us. This can include medical records and claims information related to services you may receive or have received.

We agree to keep this information confidential. Consistent with our Notice of Privacy Practices, this information will be used and disclosed only as authorized by law.

Reliance on Verbal Communications

If we tell you a member is eligible for coverage or benefits are available, this does not guarantee that claims will be paid. Claims are paid only after:

- The reported diagnosis is reviewed
- Medical necessity is verified
- Benefits are available when the claim is processed

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Right to Interpret Contract

During claims processing and internal grievances, BCBSM reserves the right to interpret and administer the terms of this certificate and any riders that amend it. BCBSM's final adverse decisions regarding claims processing and grievances may be appealed under applicable law.

Services Before Coverage Begins and After Coverage Ends

- We will not pay for any services, treatment, care or supplies ordered or provided before the effective date of this certificate.
- We will not pay for any services, treatment, care or supplies provided after the date on which coverage under this certificate ends. The only exception will be for eyeglasses and contact lenses ordered before, but received within 60 days after, coverage ends.

Services That Are Not Payable

We do not pay for services that:

- You would not have been charged if you did not have coverage under this certificate
- Are available in a hospital maintained by the state or federal government, unless payment is required by law
- Can be paid by government-sponsored health care programs, such as Medicare, for which a member is eligible. We do not pay for these services even if you have not signed up to receive the benefits from these programs. However, we will pay for services if federal laws require the government-sponsored program to be secondary to this coverage.
- Are more costly than an alternate service or sequence of services that are at least as likely to produce equivalent results
- Are not listed in this certificate as being payable

Subrogation: When Others Are Responsible for Illness or Injury

If BCBSM paid claims for an illness or injury, and:

- Another person caused the illness or injury, or
- You are entitled to receive money for the illness or injury

Then BCBSM is entitled to recover the amount of benefits it paid on your behalf.

Subrogation is BCBSM’s right of recovery. BCBSM is entitled to its right of recovery even if you are not “made whole” for all of your damages in the money you receive. BCBSM’s right of recovery is not subject to reduction of attorney’s fees, costs, or other state law doctrines such as common fund.

Whether you represented by an attorney or not, this provision applies to:

- You
- Your covered dependents

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Subrogation: When Others are Responsible for Illness or Injury (continued)

You agree to:

- Cooperate and do what is reasonably necessary to assist BCBSM in the pursuit of its right of recovery
- Not take action that may prejudice BCBSM's right of recovery
- Permit BCBSM to initiate recovery on your behalf if you do not seek recovery for illness or injury
- Contact BCBSM promptly if you:
  - Seek damages
  - File a lawsuit
  - File an insurance claim or demand or
  - Initiate any other type of collection for your illness or injury

BCBSM may:

- Seek first priority lien on proceeds of your claim in order to fulfill BCBSM's right of recovery
- Request you to sign a reimbursement agreement
- Delay the processing of your claims until you provide a signed copy of the reimbursement agreement
- Offset future benefits to enforce BCBSM's right of recovery

BCBSM will:

- Pay the costs of any covered services you receive that are in excess of any recoveries made

Examples where BCBSM may utilize the subrogation rule are listed below.

BCBSM can recover money it paid on your behalf if another person or insurance company is responsible:

- When a third party injures you, for example, through medical malpractice
- When you are injured on premises owned by a third party or
- When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to Medical reimbursement coverage

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Termination of Coverage

You must provide the required notification if you want to terminate your coverage under this certificate.

Send your written request to terminate coverage to your group. Your group must notify BCBSM within 30 days of the requested termination date. Your coverage will then be terminated on the requested date an all benefits under this certificate will end.

Time Limit for Filing Pay-Provider Claims

The time limit for filing these claims is 180 days from the date of service. We will not pay claims filed after that date.

Time Limit for Filing Pay-Subscriber Claims

The time limit for filing these claims is 12 months from the date of service. We will not pay claims filed after that date.

Time Limit for Legal Action

You may not begin legal action against us later than three years after the date of service of your claim. If you are bringing legal action about more than one claim, this time limit runs independently for each claim.

You must first exhaust the grievance and appeals procedures, as explained in this certificate, before you begin legal action. You cannot begin legal action or file a lawsuit until 60 days after you notify us that our decision under the grievance and appeals procedure is unacceptable.

Unlicensed and Unauthorized Providers

We do not pay for services provided by persons who are not:

- Appropriately credentialed or privileged (as determined by BCBSM), or
- Legally authorized or licensed to order or provide such services.

What Laws Apply

This certificate will be interpreted under the laws of the state of Michigan and federal law where applicable.

Workers' Compensation

We do not pay for treatment of work-related injuries covered by workers compensation laws. We do not pay for work-related services you get at an employer's medical clinic or other facility.

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Section 6: Definitions

This section explains the terms used in your certificate.

Adverse Benefit Decision
A decision to deny, reduce or refuse to pay all or part of a benefit. It also includes a decision to terminate or cancel coverage.

Approved Amount
The lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Association Health Plan (AHP)
An AHP provides benefits to the employees of two or more unrelated employers. An AHP also may provide benefits to self-employed individuals who own, either alone or in a partnership, a trade or business. Each AHP must adhere to applicable federal and state statutes and regulations.

BCBSM
Blue Cross Blue Shield of Michigan.

Calendar Year
A period of time beginning January 1 and ending December 31 of the same year.

Cancellation
An action that ends a member's coverage dating back to the effective date of the member's contract. This results in the member's contract never having been in effect.

Certificate
This book, which describes your benefit plan **and** any riders that amend it.

Claim for Damages
A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.

COBRA Coverage
Consolidated Omnibus Budget Reconciliation Act (COBRA) – A Federal law that may allow you to temporarily keep your health coverage after:

- Your employment ends
- You lose coverage as a dependent of the covered employee, or
- Another qualifying event

If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay for you plus a small administrative fee.

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Coinsurance
A portion of the approved amount that you must pay for a covered service. This amount is determined based on the approved amount at the time the claims are processed. Your coinsurance is not altered by any audit, adjustment, or recovery.

Contact Lenses
Contact lenses prescribed by a physician or optometrist to correct or improve vision. They are fitted directly to the patient's eye.

Contract
This certificate and any related riders, your signed application for coverage and your BCBSM ID card.

Copayment
The dollar amount that you must pay for a covered service. Your copayment is not altered by any audit, adjustment or recovery.

Cost Sharing
Copayments, coinsurances, and deductibles you must pay under this certificate.

Covered Services
A health care service that is identified as payable in this certificate. Such services must be medically necessary, as defined in this certificate, and ordered or performed by a provider that is legally authorized or licensed to order or perform the service. The provider must also be appropriately credentialed or privileged, as determined by BCBSM, to order or perform the service.

Deductible
The amount that you must pay for covered services, under any certificate, before benefits are payable. Payments made toward your deductible are based on the approved amount at the time of the claims are processed. Your deductible is not altered by an audit, adjustment, or recovery.

Department of Insurance and Financial Services (DIFS)
The department that regulates insurers in the state of Michigan.

Effective Date
The day your coverage begins under this contract. This date is established by BCBSM.

Exclusions
Situations, conditions or services that are not covered by the subscriber's contract.

Experimental and Investigational Treatment
Treatment that has not been scientifically proven to be as safe and effective for treatment of the patient's conditions as conventional treatment. Sometimes it is referred to as “investigational” or “experimental services.

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First Priority Security Interest
The right to be paid before any other person from any money or other valuable consideration recovered by:

- Judgment or settlement of a legal action
- Settlement not due to legal action
- Undisputed payment

This right may be invoked without regard for:

- Whether plaintiff's recovery is partial or complete
- Who holds the recovery
- Where the recovery is held

Frames
Standard frames into which two lenses may be fitted.

Group
An employer or association of employers that provides its members with health care coverage. An employer may provide different health care benefits to different segments or categories of its members. A group can also include participants of a trust fund that has been established to purchase health care coverage pursuant to collective bargaining agreements.

In-Network Provider
An ophthalmologist, optometrist, optician or retail vision provider that has a signed agreement with BCBSM to offer services through this PPO program. In-network providers have agreed to accept our approved amount as payment in full for covered services provided d under this PPO program.

Lenses
Glass or plastic lenses prescribed by an ophthalmologist or optometrist to correct or improve vision. They are fitted into frames.

Lien
A first priority security interest in any money or any action to recover money for the treatment of injuries for which we paid benefits.

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Medical Necessity or Medically Necessary
A determination by vision specialists for BCBSM, based upon criteria and guidelines developed by vision specialists for BCBSM, or, in the absence of such criteria and guidelines, based upon vision specialist review, in accordance with accepted professional standards and practices, that the service:

- Is accepted as necessary and appropriate for the patient's condition and
- Is not mainly for the convenience of the member or provider, and
- In the case of diagnostic testing, the tests are essential to and are used in the diagnosis and/or management of the patient's condition.

For the purposes of medical necessity determinations only, vision specialist excludes opticians, optometrists and retail vision providers.

Member
Any person eligible for health care services under this certificate on the date the services are provided. This means the subscriber and any eligible dependent listed on the application. The member is the "patient" when receiving covered services.

Ophthalmologist
A licensed doctor of medicine or osteopathy who, within the scope of his or her license, performs eye exams and prescribes corrective lenses.

Optician
A specialist who fits eyeglasses and makes lenses to correct vision problems.

Optometrist
A person licensed to practice optometry in the state the service is provided.

Out-of-Network Provider
An ophthalmologist, optometrist, optician or retail vision provider that has not signed an agreement to provide services under this PPO program. Out-of-Network providers have not agreed to accept the approved amount as full payment for covered services.

Pay-Provider Claim
This is a type of claim where Blue Cross pays your provider directly according to the terms of your coverage.

Pay-Subscriber Claim
This is a type of claim where Blue Cross will reimburse you, the subscriber, according to the terms of your coverage. Either you or your provider may submit this type of claim.

Plaintiff
The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.

Post-Service Grievance
A post-service grievance is an appeal that you file when you disagree with our payment decision or our denial for a service that you have already received.

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Pre-Service Grievance
A pre-service grievance is an appeal that you can file when you disagree with our decision not to preauthorize a service you have not yet received.

Prior Authorization
Some vision benefits services require prior authorization before you receive them. If you receive those services without first obtaining prior authorization, you may have to pay the bill yourself. We may not pay for it. It is important to make sure that your provider gets the prior authorization before you receive the services.

Provider
An ophthalmologist, optometrist, optician or retail vision provider that provides services related to vision care.

Qualified Beneficiary
Persons eligible for continued group coverage under COBRA. This includes the employee, spouse and children (including those born to, or placed for adoption with, the employee during the period of COBRA coverage).

Qualifying Event
One of the following events that allows you to enroll in different health care coverage or change your current coverage:

- Termination of employment, other than for gross misconduct, or reduction of hours
- Start of Military Service. Members must perform military duty for more than 30 days.
- Death of the employee
- Divorce
- Loss of dependent status due to age, marriage, change in student status, etc.
- The employee becomes entitled to coverage under Medicare

The examples in this definition are not exhaustive and may change. Please call Customer Service for more information about qualifying events.

Reimbursement
The fee BCBSM allows for a procedure is based on the lesser of the amount billed or the BCBSM maximum payment level for that procedure on the date the service is rendered.

Remitting Agent
Any individual or organization that has agreed on behalf of the member to:

- Collect or deduct premiums from wages or other sums owed to the subscriber and
- Pay the subscriber's BCBSM bill

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Rescission
The cancellation of coverage that dates back to the effective date of the member's contract and voids coverage during this time.

Retail Vision Provider
A retail vision provider is a chain of four or more stores providing vision services. A retailer may be in-network or out-of-network.

Rider
A document that amends a certificate by adding, limiting, deleting or clarifying benefits.

Right of Recovery
The right of BCBSM to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by BCBSM.

Spouse
An individual who is legally married to the subscriber and meets the group's eligibility requirements.

Subrogation
Subrogation occurs when BCBSM assumes the right to make a claim against or to receive money or other thing of value from another person, insurance company or organization. This right can be your right or the right of your dependents or representatives.

Subscriber
The person who signed and submitted the application for coverage and meets the group's eligibility requirements.

Termination
An action that ends a member's coverage after the member's contract takes effect. This results in the member's contract being in effect up until the date it is terminated.

Vision Specialists
Licensed MDs and DOs who are board certified or board qualified in the specialty of ophthalmology, licensed optometrists, opticians and retailer vision providers.

VSP
Vision Service Plan©.

We, Us, Our
Used when referring to Blue Cross Blue Shield of Michigan and to VSP.

You and Your
Used when referring to any person covered under a subscriber's contract.

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Section 7: Additional Information You Need to Know

We want you to be satisfied with how we administer your coverage. If you have a question or concern about how we processed your claim or request for benefits, we encourage you to contact Vision Service Plan Customer Service. The telephone number is (800) 877-7195 (or 800-428-4833 for TDD/TTY) and on the back of your Blues ID card.

Grievance and Appeals Process

Through VSP, we have a formal grievance and appeals process that allows you to dispute an adverse benefit decision or rescission of your coverage.

An adverse benefit decision includes a:

- Denial of a request for benefits
- Reduction in benefits
- Failure to pay for an entire service or part of a service
- Rescission of coverage

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, such as a cancellation that treats a policy as void from the time of enrollment.

You may file a grievance or appeal about any adverse benefit decision within 180 days after you receive the claim denial. The dollar amount involved does not matter.

If you file a grievance or appeal:

- You will not have to pay any filing charges
- You may submit materials or testimony at any step of the process to help us in the review.
- You may authorize another person, including your physician, to act on your behalf at any stage in the standard review process. Your authorization must be in writing. Please call the VSP Customer Service number (800-877-7195 or 800-428-4833 for TDD/TTY) on the back of your Blues ID and ask for a *Designation of Authorized Representative and Release of Information* form. Complete it and send it with your appeal.
- Although we have 60 days to give you our final determination for post-service appeals, you have the right to allow us additional time if you wish.
- You do not have to pay for copies of information relating to our decision to deny, reduce, terminate or cancel your coverage.

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Grievance and Appeal Process (continued)

The grievance and appeals process begins with an internal review by VSP. Once you have exhausted your internal options, you have the right to a review by the Michigan Department of Insurance and Financial Services.

You do not have to exhaust the internal grievance process before requesting an external review in certain circumstances if:

- We waive the requirement.
- We fail to comply with the internal grievance process.
  - Our failure to comply must be for more than minor violations of the internal grievance process.

    Minor violations are those that do not cause and are not likely to cause you prejudice or harm.

Standard Internal Review Process

Step 1: You or your authorized representative sends VSP a written statement explaining why you disagree with our decision.

Mail your written grievance to:

VSP Appeals
P.O. Box 2350
Rancho Cordova, CA 95741

Step 2: VSP will contact you to schedule a conference once they receive your grievance. During your conference, you can provide VSP with any other information you want them to consider in reviewing your grievance. You can choose to have the conference in person or over the telephone. The written decision VSP gives you after the conference is the final decision.

Step 3: If you disagree with the final decision, or you do not receive the decision within 60 days after VSP received your original grievance, you may request an external review. See below for how to request a standard external review.

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Standard External Review Process

Once you have gone through the standard internal review process, you or your authorized representative may request an external review.

The standard external review process is as follows:

Within 127 days of the date you receive or should have received the final decision, send a written request for an external review to the Department listed below.

You may mail your request and the required forms to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may also contact the Department with your request by phone, fax, or online:

Phone: 877-999-6442
Fax: 517-284-8837
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

When you file a request for an external review, you will have to authorize the release of medical records that may be required to reach a decision during the external review.

If you ask for an external review about a medical issue and the issue is found to be appropriate for external review, the Department will assign an independent review group to conduct the external review. The group will consist of independent clinical peer reviewers. The recommendation of the independent review group will only be binding on you and us if the Department decides to accept the group's recommendation. The Department will make sure that this independent review group does not have a conflict of interest with you, with us, or with any other relevant party.

Reviews of Medical Issues

Step 1: The Department will assign an independent review group to review your request if it concerns a medical issue that is appropriate for an external review.

- You will have the chance to provide additional information to the Department within seven days of sending your request for an external review. We must give the independent review group all of the information we considered when we made a final decision, within seven days of getting notice of your request from the Department.

Step 2: The review group will recommend within 14 days whether the Department should uphold or reverse our decision. The Department must decide within seven business days whether to accept the recommendation and then notify you of its decision. The decision is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

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Grievance and Appeals Process (continued)

Reviews of Nonmedical Issues

Step 1: Department's staff will review your request if it involves nonmedical issues and is appropriate for external review.

Step 2: They will recommend if the Department should uphold or reverse our decision. The Department will notify you of the decision. This is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Expedited Internal Review Process

If you have filed a request for an expedited internal review, you or your authorized representative may ask for an expedited external review from the Department of Insurance and Financial services.

- You may file a request for an expedited internal review if your physician shows (verbally or in writing) that following the timeframes of the standard internal process will seriously jeopardize:
  - Your life or health, or
  - Your ability to regain maximum function

You may request an expedited internal review if you believe:

- We wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive it, or
- We failed to respond in a timely manner to a request for benefits or payment

The process is as follows:

Step 1: Call (800) 877-7195 (800-428-4833 for TDD/TTY) to ask for an expedited review. Your physician should also call this number to confirm that you qualify for an expedited review.

Step 2: We must give you our decision within 72 hours of getting both your grievance and the physician's substantiation.

Step 3: If you do not agree with the decision, you may, within 10 days of receiving it, request an expedited external review.

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Expedited External Review Process

If you have filed a request for an expedited internal review, you or your authorized representative may ask for an expedited external review from the Department of Insurance and Financial services.

You may request an expedited external review if you believe:

- We wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive it, or
- We failed to respond in a timely manner to a request for benefits or payment

The process is as follows:

Step 1: A request for external review form will be sent to you or your representative with the final adverse determination.

Step 2: Complete this form and mail it to:

Department of Insurance and Financial Services
Office of General Counsel
Health Care Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may also contact the Department with your request by phone, fax, or online:

Phone: 877-999-6442
Fax: 517-284-8837
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

When you file a request for an external review, you will have to authorize the release of medical records that may be required to reach a decision during the external review.

Step 3: The Department will decide if your request qualifies for an expedited review. If it does, the Department will assign an independent review group to conduct the review. The group will recommend within 36 hours if the Department should uphold or reverse our decision.

Step 4: The Department must decide whether to accept the recommendation within 24 hours. You will be told of the Department's decision. This decision is the final administrative decision under the Patient's Right to Independent Review Act of 2000.

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Pre-Service Appeals

For members who must get approval before obtaining certain health services.

Your plan may require prior authorization of certain health services. If prior authorization is denied, you can appeal this decision.

Please follow the steps below to request a review. If you have questions or need help with the appeal process, please call the VSP Customer Service number (800-877-7195 or 800-428-4833 for TDD/TTY) on the back of your Blues ID card.

All appeals must be requested in writing. VSP must receive your written request within 180 days of the date you received notice that the service was not approved.

Requesting a Standard Pre-Service Review

You may make the request yourself, or your professional provider or someone else acting on your behalf may make the request for you. If another person will represent you, that person must obtain written authorization to do so. Please call the VSP Customer Service number (800-877-7195 or 800-428-4833 for TDD/TTY) on the back of your Blues ID and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.

Your request for a review must include:

- Your contract and group numbers, found on your Blues ID card
- A daytime phone number for both you and your representative
- The patient's name if different from yours
- A statement explaining why you disagree with our decision and any additional supporting information

Once we receive your appeal we will provide you with a final decision within 30 days.

Requesting an Urgent Pre-Service Review

If your situation meets the definition of urgent under the law, your request will be reviewed as soon as possible; generally within 72 hours. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician; you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an urgent review or a simultaneous expedited external review.

See above for the steps to follow to request an expedited external review.

For more information on how to ask for an urgent review or simultaneous expedited external review, call the VSP Customer Service number (800-877-7195 or 800-428-4833 for TDD/TTY) listed on the back of your Blues ID card.

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Need More Information?

At your request and without charge, we will send you details from your health care plan if our decision was based on your benefits. If our decision was based on medical guidelines, we will provide you with the appropriate protocols and treatment criteria. If we involved a medical expert in making this decision, we will provide that person's credentials.

To request information about your plan or the medical guidelines used, or if you need help with the appeal process, call the VSP Customer Service number (800-877-7195 or 800-428-4833 for TDD/TTY) on the back of your Blues ID card.

Other Resources to Help You

For questions about your rights, this certificate, or for assistance, call the Employee Benefits Security Administration at 1-866-444-EBSA (3272). You can also contact the Director of the Michigan Department of Insurance and Financial Services for assistance.

To contact the Director:

- Call toll-free at **1-877-999-6442** or
- Fax at 517-284-8837; or
- Online at https://difs.state.mi.us/Complaints/ExternalReview.aspx; or
- Mail to: Department of Insurance and Financial Services
P.O. Box 30220
Lansing, MI 48909-7720

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We Speak Your Language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ܐܢ ܐܢܬܘܢ، ܐܘ ܚܕ ܦܪܨܘܦܐ ܕܩܐ ܡܥܕܪܝܬܘܢ ، ܣܢܝܩ ܠܗ ܠܥܘܕܪܢܐ، ܐܢܬܘܢ ܐܝܬ ܠܟܘܢ ܙܕܩܐ ܠܡܩܒܠܬ ܥܘܕܪܢܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܕܠܐ ܦܠܛܐ. ܠܡܡܠܠܬܐ ܥܡ ܚܕ ܡܦܫܩܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܕܚܠܡܬܐ ܕܙܒܘܢܐ ܥܠ ܒܣܬܪܐ ܕܟܪܛܝܣܟܘܢ ܐܘ 877-469-2583 TTY:711 ܐܢ ܗܠܐ ܠܝܬܘܢ ܗܕܡܐ.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

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Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は 877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

Important Disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *https://www.hhs.gov/ocr/office/file/index.html*.

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Section 8: How to Reach VSP

This section lists phone numbers and addresses to help you get information quickly.

Call Us

For eligibility and membership questions, please call BCBSM at the phone number on the back of your ID card.

Call VSP

If you have questions about your vision coverage, call VSP at: **1-800-877-7195**

Check the VSP Website

Visit VSP online at **www.vsp.com**.

Write VSP

Send claims for services of out-of-network providers to:

VSP Claim Services
P. O. Box 385018
Birmingham, AL 35238-5108

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