





Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

BLUE CROSS® VISION GLASSES AND CONTACTS INDIVIDUAL MARKET STAND-ALONE BENEFITS CERTIFICATE

Blue Cross Blue Shield of Michigan 10-Day Money-Back Guarantee

Blue Cross Blue Shield of Michigan is committed to the health and satisfaction of our members. If for any reason you are unsatisfied and wish to terminate your coverage, simply notify BCBSM in writing within 10 days of the effective date of your coverage. You will receive a full refund of your premium. If you terminate your coverage after 10 days, you will receive a pro-rated refund of the unused portion of your premium. Please see the "How to Reach Heritage" section of this certificate for our mailing address and Customer Service telephone numbers.

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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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BLUE CROSS® VISION GLASSES AND CONTACTS INDIVIDUAL MARKET STAND-ALONE BENEFITS CERTIFICATE

We are pleased you have selected Blue Cross Blue Shield of Michigan 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 services. Please read it carefully. If you have any questions about your coverage, call us at one of the BCBSM Customer Service telephone numbers listed in the "How to Reach Heritage" section of this book.

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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 Heritage**
- **Index**

This certificate provides you with the information you need to get the most out of your **Blue Cross® Vision** coverage.

If you have any questions about your vision coverage, please call Heritage Customer Service department at 1-800-252-2053.

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 **member** 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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Table of Contents

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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
- **WHEN YOU CAN ENROLL**
- **WHEN YOUR BENEFITS BEGIN**
- **CHANGING YOUR COVERAGE**
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ELIGIBILITY

You will need to complete an application for coverage.

We will review your application to determine if you and the people you list on it are eligible for coverage. Our decision will be based on the eligibility rules in this certificate and our underwriting policies.

If you or anyone applying for coverage on your behalf commits fraud or intentionally lies about a material fact when filling out the application, your coverage may be rescinded. See “Rescission” on Page 7.

If you or anyone applying for coverage on your behalf lies about your tobacco use or state or county of residence, we have the right to get back from you the difference in premium from what you are paying and what you should have paid.

Who Is Eligible for Coverage

You, your spouse and the dependents you have listed on your application are eligible for coverage if they:

- Are current residents of Michigan on the effective date of coverage and U.S. citizens or lawfully present in the United States and must intend to reside in the state. Everyone on your contract must intend to live in Michigan except in the case of individuals living outside of Michigan temporarily (as in the case with college students or snowbirds.)

To get coverage, you must send us a completed application. We will review your application to determine if you and the people you list on it are eligible for coverage. Our decision will be based on the terms in this certificate and our underwriting policies in effect at the time you apply for coverage.

Who Is Eligible to Receive Benefits

We will pay for services listed in this certificate and any accompanying riders only for you, your spouse and your dependent children age 19 or older on the plan’s effective date.

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 eligible for coverage under this certificate.

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Who Is Eligible to Receive Benefits (continued)

Disabled Unmarried Children

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
- They depend on you for support and maintenance.

You 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.

A dependent child or spouse who becomes ineligible for coverage under this contract may be eligible for their own contract. However, we must be notified within 60 days of the date the person becomes ineligible. Members who lose their coverage may apply for other vision coverage if available, as long as it is within 60 days of the date this coverage ends or during the annual enrollment period. If you choose other vision coverage, it must be with a medical plan or dental plan that includes vision.

WHEN YOU CAN ENROLL

- During the annual open enrollment period
- At any time during the year; this coverage does not require a qualifying life event

WHEN YOUR BENEFITS BEGIN

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

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CHANGING YOUR COVERAGE

You may change your coverage at any time during the year.

You can change who can 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:

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

There may be changes in your family while you have coverage under this certificate. To **remove** a dependent or spouse from your plan, you must notify BCBSM within 60 days of the requested removal date. Coverage will end on the requested date.

We must receive notice from you within 60 days of the requested date to **add** a dependent or spouse. You must provide supporting proof of your qualifying event. For a list of supporting proof by event, please visit bcbsm.com/documents.

If a member on this contract dies, please notify us, and your rate will be adjusted as of the date of death. If the subscriber dies, the contract must be rewritten to reflect a new subscriber and the rate will be adjusted. In either event, you may not change your coverage until the next open enrollment period, except as established by federal law.

Once you receive your new ID card, do not use your old ID card. However, keep your old card until all claims under your prior vision certificate or contract have been resolved.

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BILLING

Information About Your Bill

Each bill for a regular billing cycle covers a one-month period.

- You are responsible for the entire premium amount.
- You must pay your premium by the due date printed on your bill. When we receive your payment, we will continue your coverage through the period for which you have paid.
- If we do not receive your premium by the due date, then we will allow you a grace period of 31 days, during which we will send you a final bill. If we do not receive your premium payment during the grace period, then your coverage will be terminated or cancelled as of the last day of paid coverage.

We will accept payment of your vision insurance premium only from you, your spouse, or when appropriate, from a parent, blood relative, legal guardian or other person or entity that is allowed by law to pay your premium on your behalf.

How Rates Are Classified

Your rate will be based upon certain rating factors, such as age and where you live, in accordance with federal law.

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TERMINATION

How to Terminate Your Coverage

Call or send us your written request to terminate coverage at the phone number or address listed in Section 8, “How to Reach Heritage.” You can also call the phone number on your BCBSM identification card.

We will accept requests to terminate your coverage only from you. Your coverage will be terminated on the future date that you requested. All benefits under this certificate will end. You may be entitled to a refund of your premium.

If you decide to terminate your coverage within 10 days after the date that it is effective, you will be given a full refund of the premium that you paid. If you decide to terminate your coverage after it has been effective for 10 days, you will be given a pro-rated refund of any unused portion of the premium that you paid.

If you voluntarily terminate your coverage and your premium is due, BCBSM reserves the right to collect this premium from you.

This vision product has two different types of rates:

- A monthly premium rate
- An annual premium rate

If you cancel your contract, you and the members on your contract will still have access to your benefits until the end of the pre-paid term.

Refunds – Monthly Rate
If you paid monthly, we will terminate your coverage on the day you request it or a future date if you request it. If **no one on the contract has used benefits,** we will refund your premium for the remainder of the month in which you terminated your coverage.

If you pay for the month of April (and no one on the contract has used benefits) and ask to terminate coverage on April 20, we will refund your premium for the remaining 10 days in April.

Refunds – Annual Rate
If you paid an annual premium, your coverage will be terminated on the day that you request it or a future date if you request it. **If no one on the contract has used benefits,** we will process the refund on the first of the following month in which you asked for a refund.

You pay your annual premium in January for coverage through December. If you call in May to terminate your coverage, we will terminate your coverage as of June 1. You will be entitled to a refund for the remaining premium amount only if no one on your contract has **used vision benefits during the prepaid period.**

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Termination (continued)

How We Terminate Your Coverage

We will terminate your coverage if:

- You no longer qualify for coverage under this certificate
- You do not pay your bill on time
- You are serving a criminal sentence for defrauding BCBSM
- You cannot provide proof you live in Michigan except in the case for individuals living outside of Michigan temporarily (as in the case with college students or snowbirds).
- We no longer offer this coverage
- 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 will end on the last day covered by your 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.

If we terminate or cancel your coverage, then we will provide you with 30 days' notice, along with the reason for the termination or cancellation.

Rescission

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

- Performed an act, practice, or omission that constitutes fraud, or
- Intentionally lied about a 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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Section 2: What You Must Pay

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

The basic copayments you must pay each year 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	
Copayment Requirements	$5 per eye exam $10 per prescription glasses $0 elective contact lenses $10 medically necessary contact lenses
Benefit Maximums	$150 for frames $150 elective contact lenses
Out-of-Network	
Copayment Requirements	$5 per eye exam $10 per prescription glasses $10 medically necessary contact lenses
Benefit Maximums	None

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Copayment Requirements

Your copayment applies to in-network and out-of-network services. However, when you obtain services from an out-of-network provider, you are also responsible for paying the difference between our approved amount and the amount charged by the provider.

You are required to pay copayments on select covered services:

Routine Eye Examinations

- Your copayment is **$5**.

Standard Lenses, Lens Options (In-Network) and Frames

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

Contact Lenses

- Your copayment is **$10** for medically necessary contact lenses when you get them from an in-network provider.
- The criteria used to decide if contact lenses are medically necessary are on Page 13.
- 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 in-network (Heritage) or out-of-network provider.

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In-Network Providers

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

- Routine eye examinations
- Standard lenses, lens options specified 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 what we pay and the amount charged by the provider.

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

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

Out-of-Network Providers

We pay our approved amount, minus your copayment, for exams, lenses and frames and prescribed medically necessary contact lenses that you receive 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 paying 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. To find out the current amount, contact Heritage (see Section 8, How to Reach Heritage).

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 Heritage for the address to send claims.

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Section 3: Coverage for Vision Care Services

This section describes covered vision services to detect, improve or correct vision problems.

Frequency

We pay for:

- One eye exam every 12 months
- One pair of lenses every 12 months
- Contact lenses every 12 months
- One pair of frames every 12 months
- $150 allowance for frames
- $150 elective contact lenses

Both glasses **and** contact lenses are covered every 12 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

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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.
- 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

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.

We pay for the following lens options in-network only:

- Progressive lenses
- Anti-reflective lenses
- UV coating
- Photochromatic lenses

The lens options are not covered out-of-network.

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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.

Contact Lenses

We pay for a contact lens suitability exam that 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, less your copayment, when provided in-network. 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.

Our approved amount for non-medically necessary contact lenses is less than our approved amount for medically necessary contact lenses. 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:

- Antireflective lenses out-of-network
- 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 out-of-network
- Progressive/multifocal lenses out-of-network
- 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 received as a result of an eye disease, defect or injury due to an act of war, declared or undeclared
- Services available at no cost to you or for which no charge would be made in the absence of BCBSM coverage
- Lenses or frames ordered while you were eligible for benefits but delivered more than 60 days after coverage ends

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Exclusions (continued)

- Completing insurance forms
- Aphakic lenses when the member lacks a natural lens
- Poor-quality services
- Medically unnecessary services, glasses or contact lenses
- 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 member'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.

Change of Beneficiary

Unless the insured makes an irrevocable designation of beneficiary, the insured has the right to change the beneficiary under this policy. Consent of a beneficiary is not required to surrender this policy, for the assignment of the policy, to change a beneficiary, or to make any other changes in the policy.

Changes in Your Address

You 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

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

We must receive notice from you within 60 days of when a dependent or spouse is removed from coverage, and within 60 days of when a dependent or spouse is added. Contract changes take effect as of 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 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.

Claim Forms

The insurer, upon receipt of a notice of claim, will furnish to the claimant the forms that are usually furnished for filing proofs of loss. If the forms are not furnished within 15 days after the giving of the notice, the claimant is considered 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 proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

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Coordination of Benefits

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

It is the member's responsibility to provide complete and accurate information when requested by us to coordinate benefits. Failure to provide the requested information, including information about other coverage, may result in denial of claims. If claims are not covered due to your failure to update this information, you may be responsible for the full amount of your provider's charges.

Provisions per Michigan's Coordination of Benefits Act (MCL 550.253)

Guidelines to Determine Primary Coverage If You Are Covered by Two or More Plans

(1) If an individual is covered by 2 or more plans, the rules for determining the order of benefit payments are as follows:

(a) The insurer that issues the primary plan shall pay or provide benefits as if a secondary plan does not exist.
(b) If the individual is covered by more than 1 secondary plan, the order of benefit determination rules under this act determine the order under which secondary plan benefits are determined in relation to each other. An insurer that issues a secondary plan shall take into consideration the benefits of the primary plan and the benefits of any other plan that are, under this act, determined to be payable before those of the secondary plan.
(c) Subject to subdivision (d), a plan that does not contain order of benefit determination provisions that are consistent with this act is always the primary plan unless the provisions of both plans, regardless of this subdivision, state that the complying plan is primary.
(d) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the insurer that issues the secondary plan shall pay or provide benefits as if it were the primary plan if a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the insurer that issued the primary plan.

Order of Benefit Payments

(2) The order in which benefits are payable by insurers that issue plans are determined by using the first of the following rules that applies:

(a) The nondependent/dependent rule. If the individual is not a dependent but is an employee, member, subscriber, policyholder, or retiree under 1 plan and is a dependent under another plan, the order of payment of benefits under the plans is determined as follows:

(i) Except as otherwise provided in subparagraph (ii), the plan that covers the individual other than as a dependent is the primary plan and the plan that covers the individual as a dependent is the secondary plan.
(ii) If the individual is a Medicare beneficiary and, as a result of the provisions of title XVIII of the social security act, 42 USC 1395 to 1395lll, Medicare is secondary to the plan covering the individual as a dependent and primary to the plan covering the individual as other than a dependent, then the order of benefits is reversed and the plan covering the individual as other than a dependent is the secondary plan and the plan covering the individual as a dependent is the primary plan.

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Coordination of Benefits (continued)

(b) The dependent covered under more than 1 plan rule. If the individual is a dependent child, unless there is a court order or judgment stating otherwise, the order of payment of benefits under the plans covering the dependent child is determined as follows:

(i) If the child's parents are married or are living together, whether or not they have ever been married, as follows:

(A) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan.
(B) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

(ii) If the child's parents are divorced, separated, or not living together, whether or not they have ever been married, as follows:

(A) If a court order or judgment states that 1 of the parents is responsible for the dependent child's health care expenses or health care coverage and the insurer that issued the plan of the parent with responsibility has actual knowledge of the terms of the order or judgment, that plan is the primary plan. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This sub-subparagraph does not apply with respect to a plan year during which benefits are paid or provided before the insurer has actual knowledge of the terms of the court order or judgment.
(B) If a court order or judgment states that both parents are responsible for the dependent child's health care expenses or health care coverage, the order of benefits is determined in the manner prescribed in subparagraph (i).
(C) If a court order or judgment states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the order of benefits is determined in the manner prescribed in subparagraph (i).
(D) If there is no court order or judgment allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows, in the following order of priority:

(i) The plan covering the custodial parent.
(ii) The plan covering the custodial parent's spouse.
(iii) The plan covering the noncustodial parent.
(iv) The plan covering the noncustodial parent's spouse.

(iii) If the child is covered under more than 1 plan of individuals who are not the parents of the child, the order of benefits is determined in the manner prescribed in subparagraph (i) or (ii), as applicable, as if those individuals were parents of the child.
(iv) If the child is covered under either or both parents' plans and is also covered as a dependent under his or her spouse's plan, the order of benefits is determined in the manner prescribed in subdivision (e). If the dependent child's coverage under his or her spouse's plan began on the same date as his or her coverage under either or both parents' plans, the order of benefits is determined by applying the birthday rule prescribed in subparagraph (i) to the dependent child's parents, as applicable, and his or her spouse.

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Coordination of Benefits (continued)

(c) The active, retired, or laid-off employee rule. If the individual is an active employee, laid-off employee, or retired employee, or is a dependent of an active employee, laid-off employee, or retired employee, the order of payment of benefits under the plans covering the individual is determined as follows:

(i) The plan that covers the individual as an active employee or as a dependent of an active employee is the primary plan. The plan that covers the individual as a laid-off employee or retired employee or as a dependent of a laid-off employee or retired employee is the secondary plan.
(ii) Subparagraph (i) does not apply if the other plan that covers the individual does not have the rule described in subparagraph (i) and, as a result, the plans do not agree on the order of benefits.
(iii) This rule does not apply if the plan that covers the member, subscriber, enrollee, or retiree or the individual as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan.

(d) The continuation coverage rule. If the individual has coverage under a right of continuation pursuant to federal or state law, the order of payment of benefits under the plans covering the individual is determined as follows:

(i) The plan that covers the individual as an employee, member, subscriber, enrollee, or retiree or as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan. The plan that covers the individual under the continuation coverage is the secondary plan.
(ii) Subparagraph (i) does not apply if the other plan that covers the individual does not have the rule described in subparagraph (i) and, as a result, the plans do not agree on the order of benefits.
(iii) This rule does not apply if the order of benefits can be determined by the rule in subdivision (a).

(e) The longer or shorter length of coverage rule. If the rules in subdivisions (a) to (d) do not determine the order of benefits, the plan that has covered the individual for the longer period of time is the primary plan and the plan that has covered the individual for the shorter period of time is the secondary plan. To determine the length of time an individual has been covered under a plan, 2 successive plans are treated as 1 if the covered individual was eligible under the second plan within 24 hours after coverage under the first plan ended. Any of the following changes do not constitute the start of a new plan:

(i) A change in the amount or scope of a plan's benefits.
(ii) A change in the entity that pays, provides, or administers the plan's benefits.
(iii) A change from 1 type of plan to another, such as from a single-employer plan to a multiple-employer plan.

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Coordination of Benefits (continued)

Length of Time Covered under a Plan

(3) A person's length of time covered under a plan is measured from the person's first date of coverage under the plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

Plan Inability to Agree on Order of Benefits

(4) If the insurers that issued plans cannot agree on the order of benefits within 30 calendar days after the insurers have received all of the information needed to pay the claim, the insurers shall immediately pay the claim in equal shares and determine their relative liabilities following payment. An insurer is not required to pay more than it would have paid had the plan it issued been the primary plan.

Amount to be Paid by the Secondary Plan

(5) Except as provided in subsection (6), in determining the amount to be paid on a claim by the insurer that issued a secondary plan, if the insurer wishes to coordinate benefits, the insurer shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply the calculated amount to any allowable expense under its plan that is unpaid under the primary plan. The insurer that issued a secondary plan may reduce its payment by the calculated amount so that, when combined with the amount paid under the primary plan, the total benefits paid or provided under all plans for the claim do not exceed 100% of the total allowable expense for the claim.

Amount to be Paid by the Secondary Plan

(6) In determining the amount to be paid on a dental plan claim by the insurer that issued a secondary plan, if the insurer wishes to coordinate benefits, it may do so in accordance with subsection (5) or, for not more than 2 years after the effective date of the amendatory act that added this subsection, it may do so under a nonduplication of benefits method. Under a nonduplication of benefits method, the primary plan payment is subtracted from the secondary plan's allowable benefit amount. If there is a positive balance, the insurer that issued the secondary plan shall make a payment equal to the difference. If there is a negative or zero balance, the insurer that issued the secondary plan shall make no payment. If an insurer that issues a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with section 223 of the internal revenue code of 1986, 26 USC 223, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the internal revenue code of 1986, 26 USC 223.

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Coordination of Benefits (continued)

Payment of Claims or Coordination of Benefits not Provided or Authorized by Health Maintenance Organization

A health maintenance organization is not required to pay claims or coordinate benefits for services that are not provided or authorized by the health maintenance organization and that are not benefits under the health maintenance contract

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.

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

We do not pay for:

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

How BCBSM Determines if a Treatment Is Experimental

If a treatment is not covered under this certificate, BCBSM's medical director will determine 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 member'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

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Experimental Treatment (continued)

- There is a written informed consent used by the treating provider in which the service is referred to as experimental or investigational or other than conventional or standard treatment.
- 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.

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.

Services That Are Payable

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).
- The services related to the experimental treatment are covered under your certificate when they are related to conventional treatment.

Limitations and Exclusions

- 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 member harm; or are not appropriate for the member'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 coverage
- Begin legal action against you
- Refuse to cover your vision care services at a later date

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Notice of Claim
Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of a loss covered by the policy, or as soon after the loss as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at Blue Cross Blue Shield of Michigan, 600 E. Lafayette, Detroit, MI 48226 or to any authorized agent of the insurer, with information sufficient to identify the insured, is considered notice to the insurer.

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

Payment of Claims
Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting the payment, which may be prescribed in this policy, and effective at the time of payment. If a designation or provision is not in effect, the indemnity is payable to the estate of the insured. Other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to the beneficiary or to the estate. All other indemnities are payable to the insured.

Payment of Covered Services
The services covered under this certificate may be combined and paid according to BCBSM’s payment policies.

Personal Costs
We will not pay for:

- Transportation and travel, even if recommended by an ophthalmologist
- Care, services, supplies or devices that are personal or convenience items
- Charges to complete claim forms
- Domestic help

Physical Examination and Autopsy
The insurer at its own expense has the right and must be given the opportunity to examine the insured at reasonable times and as frequently as reasonably required during the pendency of a claim under this policy and to make an autopsy in case of death if not forbidden by law.

Physician of Choice
You may continue to get services from the physician you choose. However, be sure to get services from an in-network physician to avoid out-of-network costs to you.

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.

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Proofs of Loss

Written proof of loss must be furnished to the insurer at its designated office. Proof of loss for a claim for loss for which this policy provides any periodic payment that is contingent upon continuing loss must be furnished within 90 days after the termination of the period for which the insurer is liable. Proof of loss for a claim for any other loss must be furnished within 90 days after the date of the loss. Failure to furnish the proof within the time required under this provision does not invalidate or reduce the claim if it was not reasonably possible to give proof within the time required if the proof is furnished as soon as reasonably possible and, unless the claimant is legally incapacitated, not later than one year after the time proof is otherwise required.

Refund of Premiums

If we determine that we must refund a premium, we will refund up to a maximum of two years of payments.

Reinstatement

If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by an agent duly authorized by the insurer to accept the premium, without requiring in connection with the acceptance of the premium an application for reinstatement, is a reinstatement of the policy. However, if the insurer or its agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy is reinstated upon approval of the application by the insurer or, if not approved by the insurer, on the forty-fifth day after the date of the conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application. Under the reinstated policy, the insurer will cover only loss resulting from accidental injury that is sustained after the date of reinstatement and loss due to sickness that begins more than 10 days after that date. In all other respects, the insured and insurer have the same rights under the policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on the policy or attached to the policy in connection with the reinstatement. The insurer will apply any premium accepted in connection with a reinstatement to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

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 date on which coverage under this certificate begins.

- We will not pay for any services, treatment, care or supplies ordered or provided after the date on which coverage under this certificate ends. The only exceptions 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 legally do not have to pay for or for which 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

- That 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.

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

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

- You
- Your covered dependents

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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Subscriber Liability

At the discretion of your provider, certain technical enhancements may be employed to complement a medical procedure. These enhancements may involve additional costs above and beyond the approved maximum payment level for the basic procedure. The costs of these enhancements are not covered by this certificate. Your provider must inform you of these costs. You then have the option of choosing any enhancements and assuming the liability for these additional charges.

Termination of Coverage

You must notify us if you want to terminate your coverage under this certificate. Once you provide us with this notice, your coverage will end on one of the following dates:

- If you notify us at least 14 days before the date you want your coverage to end, your coverage will end on your requested date, or
- If you notify us in less than 14 days before the date you want your coverage to end, we will end it on your requested date only if it is feasible for us to do so, or
- In all other cases, we will end your coverage 14 days after you request that your coverage be terminated.

If we decide to terminate your coverage under this certificate, we may notify you of our decision at least 30 days before your last day of coverage. The notification will include the reason for the termination and the date your coverage will end.

We will not terminate your coverage for any reason other than those listed on Page 6 of this certificate.

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.

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Time of Payment of Claims

Indemnities payable under this policy for a loss other than loss for which this policy provides a periodic payment will be paid immediately upon receipt of due written proof of the loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid immediately and any balance remaining unpaid on the termination of liability will be paid immediately upon receipt of due written proof.

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.

BCBSM
Blue Cross Blue Shield of Michigan or another entity or person Blue Cross Blue Shield of Michigan authorizes to act on its behalf.

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 payment for an injury to a person.

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 member'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.

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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.

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.

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

Medically Appropriate
Services that are consistent with how providers generally treat their patients. The services can be those used to diagnose or for treatment. They are based on standard practices of care and are supported by evidence of their effectiveness.

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 member'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 member'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 their 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.

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Out-of-Network Provider
An ophthalmologist, optometrist, optician or retail vision provider who 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.

Preapproval
Some vision benefits services require preapproval before you receive them. If you receive those services without first obtaining preapproval, 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 preapproval before you receive the services.

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

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

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

- Start or end of military service. Members must perform military duty for more than 30 days.
- Death of the subscriber
- Divorce
- Loss of dependent status due to age, marriage, change in student status, etc.
- The member 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.

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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

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 chain of four or more stores providing vision services. A retail vision provider 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.

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 BCBSM'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 retail vision providers.

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We, Us, Our
Used when referring to Blue Cross Blue Shield of Michigan, Heritage or another entity or person Blue Cross Blue Shield of Michigan authorizes to act on its behalf.

You and Your
Used when referring to any person covered under the 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 Heritage Vision Plans Customer Service. The telephone number is listed on the back of your ID card.

Grievance and Appeals Process

Through Heritage Vision Plans, 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 or rescission 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 Heritage Vision Plans Customer Service number 1-800-252-2053 on the back of your 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 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 BCBSM. Once you have exhausted your internal options, you have the right to a review by the Michigan Department of Insurance and Financial Services (DIFS).

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 Heritage a written statement explaining why you disagree with our decision.

Mail your written grievance to:

Heritage Vision Plans
Attn: Customer Service Manager
One Woodward Ave, Suite 2020
Detroit, MI 48226

Step 2: Heritage will contact you to schedule a conference once they receive your grievance. During your conference, you can provide Heritage 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 Heritage 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 Heritage received your original grievance, you may request an external review. See below for how to request a standard external review.

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Grievance and Appeal Process (continued)

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. You may mail your request and the required forms to:

Department of Insurance and Financial Services
Office of Research, Rules and Appeals
Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may have your request delivered by courier or delivery to:

530 W. Allegan Street, 7th Floor
Lansing, MI 48933

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

Phone: 1-877-999-6442
Fax: 517-284-8838
Email: DIFS-HealthAppeal@michigan.gov
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 can give the Department additional information within seven days of requesting 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.

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Grievance and Appeal Process (continued)

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.

Reviews of Nonmedical Issues

Step 1: The Department 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

- 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 1-(800) 252-2053 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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Grievance and Appeals Process (continued)

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.

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 Research, Rules and Appeals ~~— Appeals Section (by mail)~~
Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

You may have your request delivered by courier or delivery to:

530 W. Allegan Street, 7th Floor
Lansing, MI 48933

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

Phone: 1-877-999-6442
Fax: 517-284-8838
Email: DIFS-HealthAppeal@michigan.gov
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 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 Heritage Vision Plans Customer Service number on the back of your ID card.

All appeals must be requested in writing. Heritage Vision Plans 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 Heritage Vision Plans Customer Service number (1-800-252-2053) on the back of your 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 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, then 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 the last section, Expedited External Review, for the steps to follow when asking for a simultaneous expedited external review.

For more information on how to ask for an urgent review or simultaneous expedited external review, call the Heritage Vision Plans Customer Service number (1-800-252-2053) listed on the back of your 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 Heritage Vision Plans Customer Service number on the back of your 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

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 877-469-2583 TTY: 711 or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se ofrecen, sin costo alguno, ayuda y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 877-469-2583 TTY: 711 o hable con su proveedor.

تنبيه: إذا كنت تتحدث الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متوفرة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل برقم 877-469-2583 TTY: 711 أو تحدث إلى مزود الخدمة الخاص بك.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。请致电 877-469-2583 (TTY: 711) 或咨询您的服务提供商。

ܙܘܗܪܐ: ܐܢ ܐܢܬ ܡܡܠܠܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܬܫܡܫܝܬܐ ܕܥܘܕܪܢܐ ܠܫܢܝܐ ܒܡ ܡܓܢ ܦܬܝܚܐ ܩܠܘܝܟ. ܗܠܐ ܐܢ ܝܘܚܐ. ܐܦ ܬܫܡܫܝܬܐ ܕܥܘܕܪܢܐ ܠܡܢܝܐ ܠܡܫܚܠܦܬܐ ܕܝܗܒܬܐ ܕܡܘܕܥܢܘܬܐ ܒܫܘܟܠܐ ܡܨܝܐ ܦܬܝܚܐ ܗܠܐ ܐܢ ܝܘܚܐ. ܡܩܪܘܢ ܥܠ ܡܢܝܢܐ 877-469-2583 TTY: 711 ܐܘ ܡܡܠܠܘܢ ܥܡ ܡܦܪܢܣܢܘܢ.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ phù hợp để cung cấp thông tin bằng các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi số 877-469-2583 TTY: 711 hoặc trao đổi với người cung cấp dịch vụ của bạn.

VËMENDJE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 877-469-2583 TTY: 711 ose bisedoni me ofruesin tuaj të shërbimit.

알림: 한국어를 사용하는 경우 언어 지원 서비스를 무료로 이용할 수 있습니다. 정보를 접근 가능한 형식으로 제공받을 수 있는 적절한 보조 기구와 서비스도 무료로 이용할 수 있습니다. 877-469-2583 TTY: 711 번으로 전화하거나 담당 기관에 문의하십시오.

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 877-469-2583 TTY: 711 নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 877-469-2583 TTY: 711 lub porozmawiaj ze swoim usługodawcą.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 877-469-2583 TTY: 711 an oder sprechen Sie mit Ihrem Provider.

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'877-469-2583 TTY: 711 o parla con il tuo fornitore.

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注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。情報をアクセスしやすい形式で提供するための適切な補助器具やサービスも無料でご利用いただけます。877-469-2583 TTY: 711 までお電話いただくか、ご利用の事業者にご相談ください.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 877-469-2583 TTY: 711 или обратитесь к своему поставщику услуг.

PAŽNJA: Ako govorite srpsko-hrvatski, dostupne su vam besplatne usluge jezične pomoći. Odgovarajuća pomoćna pomagala i usluge za pružanje informacija u pristupačnim formatima također su dostupni besplatno. Nazovite 877-469-2583 TTY: 711 ili razgovarajte sa svojim pružateljem usluga.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 877-469-2583 TTY: 711 o makipag-usap sa iyong provider.

Discrimination Is Against The Law

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 (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). Blue Cross Blue Shield of Michigan and Blue Care Network does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross Blue Shield of Michigan and Blue Care Network:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provide free language services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call the Customer Service number on the back of your card. If you aren't already a member, call 877-469-2583 or, if you're 65 or older, call 888-563-3307, TTY: 711. Here's how you can file a civil right complaint if you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide these 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

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Discrimination Is Against The Law (continued)

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 website or by mail, phone, or email at:

U.S. Department of Health & Human Services
200 Independence Ave, SW
Room 509, HHH Building
Washington, D.C. 20201

Phone: 800-368-1019, TTD: 800-537-7697
Email: OCRComplaint@hhs.gov

Complaint forms are available on the U.S. Department of Health & Human Services Office for Civil Rights website

This notice is available at Blue Cross Blue Shield of Michigan and Blue Care Network's website:

https://www.bcbsm.com/important-information/policies-practices/nondiscrimination-notice/

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Section 8: How to Reach Heritage

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 Heritage

If you have questions about your vision coverage, call Heritage Vision Plans at: **1-800-252-2053**.

Check Heritage Vision Plans Website

Visit Heritage online at **www.heritagevisionplans.com**.

Write Heritage

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

Heritage Vision Plans, Inc.
One Woodward Ave, Suite 2020
Detroit, MI 48226

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