Anthem Blue Cross and Blue Shield

Blue View Vision Member Certificate

Anthem Blue View Vision

for Colorado Community College System

HSA Plan

Important Note: There are currently no participating vision providers available in Baca, Bent, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Dolores, Gilpin, Grand, Hinsdale, Jackson, Kiowa, Kit Carson, Lake, Mineral, Moffat, Montezuma, Morgan, Ouray, Park, Phillips, Pitkin, Rio Blanco, Routt, Saguache, San Juan, San Miguel, Sedgwick, Washington, Yuma.

Schedule of Benefits (Who Pays What)

This schedule is an outline of your benefits. You need to refer to the entire booklet for complete information about the benefits, conditions, limitations and exclusions of your plan.

Benefit Period: A 12 month period beginning July 1 at 12:01am Mountain Time.

Vision Care Services	Benefit Frequency	In-Network	Out-of-Network Reimbursement
Routine Eye Exam	Once every 12 months*	No charge	Up to $35
Materials Lenses, Frames, Contact Lenses, etc.		Available at Anthem Vision Preferred Prices	Not Covered

*from last date of service.

Anthem BlueCross BlueShield

Anthem Blue Cross and Blue Shield

Member Certificate

Welcome!

Thank you for choosing Anthem Blue Cross and Blue Shield (Anthem) for your vision care coverage.

The following materials make up your *certificate*:

- your *certificate* (this booklet)
- your application
- any amendments or endorsements

Your employer (also referred to as your *group*) also has the following documents which are part of the terms of your coverage:

- the group's application
- the *group contract*

This *certificate* contains important information such as what vision care services are covered and how they will be covered. It replaces any older *certificates* issued to you for your vision plan.

Within the *certificate*, *members* are referred to as "you" or "your". Anthem is referred to as "we," "us" or "our." All italicized words have special meanings and are defined in the Definitions section of this *certificate*.

Please review this *certificate* so you know the terms, conditions and benefits of your plan. Store it in a convenient place and refer to it whenever you have questions about your vision care coverage. You may also call our member services if you have questions. See the Contact Us section for important phone numbers and other contact information.

THIS IS A LIMITED BENEFIT HEALTH COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Note: There are currently no participating vision providers available in Baca, Bent, Cheyenne, Clear Creek, Conejos, Costilla, Crowley, Custer, Dolores, Gilpin, Grand, Hinsdale, Jackson, Kiowa, Kit Carson, Lake, Mineral, Moffat, Montezuma, Morgan, Ouray, Park, Phillips, Pitkin, Rio Blanco, Routt, Saguache, San Juan, San Miguel, Sedgwick, Washington, Yuma.

Contact Us

If you have questions about your coverage or need help finding a Blue View Vision network provider, please contact us.

Member Services

Please send your general inquiries, suggestions or complaints to:

Anthem Blue Cross and Blue Shield
P.O. Box 8504
Mason, OH 45040-7111
(866) 723-0515

Please send claims to:

Anthem Blue View Vision
Attention: Claims
P.O. Box 8504
Mason, OH 45040-7111
Phone: (866) 723-0515

Please send appeals to:

Anthem Blue View Vision
Attention: Appeals
555 Middle Creek Parkway
Colorado Springs, CO 80921
Phone: (866) -723-0515

Visit Us Online

Learn more about Blue View Vision, our network providers, and more by visiting us at www.anthem.com

Hours of operation

Monday – Saturday: 6:30 a.m. to 9:00 p.m. Mountain Time
Sunday: 9:00 a.m. to 6:00 p.m. Mountain Time

Table of Contents

Eligibility

You have coverage under this Certificate because of your membership with the Group. You must meet certain conditions to be covered under the Group's plan. These requirements may include waiting periods and Actively at Work standards as determined by the Group or by law, and approved by Us.

The information listed below is a summary of the conditions you have to meet to be eligible for coverage. If you need more information, see your Human Resources or Benefits Department.

Who is Eligible

Subscriber

The Subscriber is a Member in whose name the plan is issued.

If you are a new employee who has a normal work week as noted in the Employer Master Contract, you can join the plan as a Subscriber. You can ask the employer for the number of hours you must work and other rules to be enrolled.

Dependents

Your Dependents may include the following:

- Legal spouse, the Subscriber's spouse, including the partner to a civil union as recognized by Colorado law. For information on spousal eligibility please contact the Group.

- Common-law spouse, all references to spouse in this booklet include a common-law spouse.

A common law spouse is an eligible Dependent who has a valid common-law marriage in Colorado. This is the same as any other marriage and can only end by death or divorce.

- **Designated beneficiary**. Your employer may have decided to offer benefits under this plan to designated beneficiaries. Check with your employer to learn more. If they are recognized by the employer, all references to spouse in this booklet include a designated beneficiary. A Recorded Designated Beneficiary Agreement will need to be provided. A designated beneficiary is not eligible for COBRA under this booklet.

A designated beneficiary is an agreement entered into by two people for the purpose of making each a beneficiary of the other and which has been recorded with the county clerk and recorder in the county in which one of the person lives. The agreement is based on the Colorado Designated Beneficiary Act.

- Same-sex (and, subject to Our underwriting approval, opposite-sex) domestic partner. Check with your employer to see if a domestic partner will be eligible. If domestic partners are recognized by the employer, all references to spouse in this booklet include a domestic partner.

Domestic partner means a person of the same sex (or opposite sex if approved by Underwriting) is the Subscriber's sole domestic partner; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

- **Newborn child.** A newborn child born to you or your spouse is covered under your coverage for the first 31 days of birth. If the newborn is your grandchild, the newborn is usually not covered (see the "Grandchild" heading in this section)

To keep the child's coverage beyond the 31-day period, please send Us an enrollment application and change form to add the child if you have a non-family policy. We must get this form within 31 days after the birth of the child to continue coverage. You do not need to complete the form to add the child if you had family coverage at the time of birth of the child and if no additional Premium is required. Just provide Us notice within 60 days of the child's birth.

- **Adopted child**. An unmarried child (who has not reached 18 years of age) adopted while you or your spouse is enrolled will be covered for 31 days after the date of placement for adoption.

"Placement for adoption" means when a Subscriber has a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement ends when the legal obligation for support ends.

To keep the adopted child's coverage beyond the 31-day, you must send Us an enrollment application and change form to add the adopted child. We must get this form within 31 days after the placement of the child for adoption to continue coverage for the 32nd day and thereafter.

Dependent child. A child (including a stepchild or a disabled child) under 26 years of age may be covered under the terms of this booklet. Coverage stops at the end of the month in which the child turns 26. If you or your spouse have a qualified medical child support order for this child, the Dependent child is eligible for coverage, up to age 26, whether the child lives with you or your spouse.

- **Disabled Dependent child**. An unmarried child of any age who is medically certified as disabled, and dependent on the parent may be covered under the terms of this booklet. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. You and the disabled Dependent's doctor must send Us a mentally or physically disabled dependent form. You may call Us or visit Our website to get such form.

- **Grandchild.** A grandchild of yours or your spouse is not eligible for coverage unless you or your spouse are the court-appointed permanent guardians or have adopted the grandchild. You must send an enrollment application and change form and proof of the court appointment or the legal adoption. One other option is to enroll the grandchild under an individual child-only plan with, subject to its terms and conditions.

Your group may have limited or excluded the eligibility of certain Dependent types and so not all Dependents listed in this Plan may be entitled to enroll. For more specific information, please see your Human Resources or Benefits Department.

Medicare-Eligible Members

Before you turn 65, or if you qualify for Medicare in other ways, you should contact the local Social Security Administration office to establish Medicare eligibility. You should then contact the employer to talk about options.

Enrollment Process

This section lists who is eligible and what forms are needed for enrollment. Coverage starts on the Effective Date in Our files. No services before that date are covered. Note: Sending an enrollment application and change form does not guarantee you get on the plan.

Enrollment Forms

You must send Us an enrollment application and change form to add any Dependents. More forms may be needed for special Dependent status. You can get such forms from your employer, Our member services or Our website. Initial Enrollment We must receive the enrollment form within 31 days after the

date of hire or within 31 days of when the waiting period ends. The Effective Date will be determined by the waiting period. The employer can tell you the length of the waiting period.

Initial Enrollment

We must receive the enrollment form within 31 days after the date of hire or within 31 days of when the waiting period ends. The Effective Date will be determined by the waiting period. The employer can tell you the length of the waiting period.

Open Enrollment

Any eligible employee who did not enroll when they were first eligible can enroll during the employer's annual Open Enrollment period. This period is generally 31 days before the employer's anniversary date. The annual Open Enrollment period is subject to all provisions of the booklet. The employer can tell you more about the Open Enrollment period.

Newly Eligible Dependent Enrollment

You may add a Dependent who becomes newly eligible due to a qualifying event. Qualifying events include marriage, birth, placement for adoption or issuance of a court order. To add the Dependent, We must get an enrollment application and change form within 31, but no more than 60, days of the date of the event. Proof of the event, e.g., a copy of the marriage certificate or court order, must be attached to the form.

When you or your spouse are required by a court or administrative order to cover an eligible Dependent for child support, the eligible Dependent must be enrolled within 31 days of the issuance of such order. We must receive a copy of the court or administrative order with the enrollment application and change form. If you do not add the eligible Dependent within 31 days of the issuance of the order, you must wait until the next Open Enrollment to add the Dependent

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the plan prior to Open Enrollment if they qualify for special enrollment. Except as noted otherwise below, the Subscriber or Dependent must request special enrollment within 31 days of a qualifying event.

If an individual is notified or becomes aware of a qualifying event that will occur in the future, he or she may apply for coverage during the thirty (30) calendar days prior to the effective date of the qualifying event, with coverage beginning no earlier than the day the qualifying event occurs to avoid a gap in coverage. The individual must be able to provide written documentation to support the effective date of the triggering event at the time of application.

Special enrollment is available for eligible individuals who:

- Lost coverage due to death of a covered employee.

- Due to termination or reduction in number of hours of the employee's employment.

- The covered employee becomes ineligible for benefits under Title XVIII of the Federal Social Security Act, as amended.

- Lost coverage under a health benefit plan due to the divorce or legal separation of the covered employee' spouse or partner in civil union.

- Is now eligible for coverage due to marriage (including a civil union where recognized in the state where the Subscriber resides), birth, adoption, placement for adoption, placement in foster care.

- By entering into a Designated Beneficiary Agreement, if covered by the employer, or pursuant to a QMCSO or other court or administrative order mandating that the individual be covered.

- Termination of employment or eligibility for coverage, regardless of eligibility for COBRA or state continuation.

- Has a reduction in the number of hours of employment.

- Due to involuntary termination of coverage.

- Has a reduction or elimination of group contributions toward the cost of the Prior Plan.

- Lost eligibility under the Colorado Medical Assistance.

- When the employee or dependent becomes eligible for premium assistance under the Colorado Medical Assistance Act of the Children's' Basic Health Plan.

- A parent or legal guardian disenrolls a dependent, or a dependent becomes ineligible for the Children's Basic health Plan

Important Notes about Special Enrollment:

- You must request coverage within 31 days of a qualifying event (i.e., marriage, birth of child etc.). For loss of coverage under the Colorado Medical Assistance Act, coverage must be requested within 60 days of the loss of coverage. For loss of coverage under the Children's Basic Health plan coverage must be requested within 90 days of the loss of coverage.

- Evidence of prior creditable coverage is required and must be furnished by you or your prior carrier.

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment period.

Loss of State Medicaid Plan or State Child Health Insurance Program (SCHIP) - Loss of eligibility from a state Medicaid or SCHIP health plan is also a qualifying event for special enrollment for you or your Dependents. You must file an application with the employer within 60 days after coverage has ended. Also, special enrollment is allowed for the employee who becomes eligible for premium assistance, with respect to coverage under the employer's health coverage, under a state Medicaid or SCHIP health plan. This includes any waiver or demonstration project conducted under or in relation to these plans. Similarly, you must file an application with the employer within 60 days after the eligibility date for assistance is determined.

Late Entrants

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a special enrollment period, they will not be eligible to enroll until the next Open Enrollment period.

Military Service

Employees going into or coming back from military service can keep this coverage. This choice is required by the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rights

apply only to employees and their Dependents covered under the plan before the employee leaves for military service:

- The longest period of coverage under this paragraph is the lesser of.

    - o 24 months, starting on the date when the absence starts; or
    - o The day after the person was required to, but failed to, apply for or return to work.

- A person who opts to keep this coverage may be asked to pay up to 102% of the Premium. But those on active duty for 30 days or less cannot be asked to pay more than the employee's share, if any, for the coverage.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this booklet to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

Multiple Coverage Plans with Us

You may have more than one group health plan with Us or any of Our affiliates. If you don't want both plans, you can cancel one of the plans and ask for a Premium refund. But to get a refund, you must tell Us within 31 days after the dual coverage starts. If We do not get notice within 31 days, you will not get a refund of past Premium. But you can still ask Us to cancel the plan you no longer want.

How to Change Coverage

If a group provides you with multiple plan options, you may switch to another coverage offered by the Group during Open Enrollment.

How to Access Your Services

You do not need any preauthorization to receive covered services under this vision plan. However, your choice of provider may impact your out-of-pocket costs. Keep reading for more information on providers. You should also read the section Member Payment Responsibility later in this certificate to learn more about how your provider choice may affect your out-of-pocket costs.

Choosing a Provider

> **Important Note:** We do not restrict or interfere with your right to select the provider of your choice, but your benefits are reduced when you use a *provider* who is not a *participating provider*.

Participating Providers. We have a network of vision care providers for you to use. We call them *participating providers* because they have agreed to take part in our Blue View Vision network. They have agreed to provide *covered services* to you for a negotiated rate. *Covered services* you receive from a *participating provider* are considered In-Network care. Please call us or visit our website listed in the Contact Us section for help in finding a *participating provider*.

Non-Participating Providers. *Non-participating providers* are vision care *providers* that did not agree to participate in our network. They have not agreed to a negotiated rate and do not have a provider contract with us. Since *non-participating providers* have not agreed to our negotiated rate, you will most likely have more out of pocket expenses when using a *non-participating provider*. *Covered services* you receive from a *non-participating provider* are considered Out-of-Network care.

Please call us or visit our website listed in the Contact Us for help in finding a *participating provider*.

Authorized Services

In some situations, we may authorize the *participating provider* payment amount to apply to vision care received from a *non-participating provider*. We may allow this if there is no *participating provider* available for you to receive vision care. You must contact us before you receive your vision care. If during an emergency you receive vision care from a *non-participating provider*, the *participating provider* payment amount may even apply if you do not contact us in advance. If we authorize the *participating provider* payment amount for vision care from a *non-participating provider*, you may be responsible for the difference between our *maximum allowable amount* and the actual charges.

Benefits / Coverage (What is Covered)

This section tells you more about the vision care services that are covered in this plan. We will only pay for vision care that is listed in this section. We will not pay for vision care listed in the Limitations / Exclusions section.

> **Note:** Your out of pocket costs may be higher if you receive care from a non-participating provider. See the How to Access Your Services and Obtain Approval for Benefits and the Member Payment Responsibility sections for more information on *providers* and how to find a *participating provider*.

See the Schedule of Benefits at the beginning of this booklet for your copayments, allowances, and benefit frequencies.

Routine Eye Exam. Your plan covers a routine eye exam with dilation as needed. The exam is used to check all aspects of your vision. An eye exam does not include a contact lens fitting fee.

Limitations / Exclusions

We will not pay for services incurred for, or in connection with, any of the items below.

- **Work Related.** Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation law or similar law, even if you do not claim those benefits..

- **Government Treatment.** Any services given to you by a local, state or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.

- **Non-Licensed Vision Providers**. Treatment or services rendered by non-licensed providers, or treatment or services for which the provider is not required to be licensed. This includes treatment or services from a non-licensed vision provider under the supervision of a licensed physician or licensed vision provider, except as specifically provided or arranged for by us.

- **Voluntary Payment.** Services for which you are not legally obligated to pay for, services for which you receive at no charge, or for which no charge is made in the absence of insurance coverage.

- **Excess Amounts.** Any charges that exceed the benefit maximums, allowances, or for services that are received more than the allowed benefit frequency.

- **Services of Relatives**. Professional services or supplies received from a person who lives in your home or who is related to you by blood or marriage.

- **Missed or Cancelled Appointments/Completion of Forms.** For fees charged by the *provider* for missed or canceled appointments. We will also not cover charges for the completion of claims forms or for medical records or reports requested by you or the *provider*, unless required by law.

- **Uninsured.** Services that were received before your *effective date* or after your coverage ends.

- **Sunglasses.** For sunglasses and accompanying frames.

- **Safety Glasses**. For safety glasses and accompanying frames.

- **Hospital Care**. For inpatient or outpatient hospital vision care.

- **Orthoptics.** For orthoptics or vision training and any associated supplemental testing.

- **Eye Surgery.** Any diagnostic testing or medical or surgical treatment of the eyes. This includes any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and/or astigmatism. We also will not cover any contact lenses or eyeglasses required as a result of surgery.

- **Lost or Broken Lenses/Frames.** Any lost or broken lenses or frames, unless you have reached the benefit frequency stated in the Schedule of Benefits.

- **Not Specifically Listed**. For services or supplies not specifically listed in the Benefits/Coverage section or the Schedule of Benefits in this *certificate*.

- **Contact Lens Fitting Fees.** Standard and Premium contact lens fittings.

- **Cosmetic Options.** Cosmetic lens options or personalized eyewear, unless specifically listed as covered in the Benefits/Coverage section or the Schedule of Benefits of this certificate. This includes non-prescription eyewear and lenses, plano lenses or lenses that have no refractive power.

- **Low Vision.** Certain limitations on low vision.

- **Discounted Services or Supplies.** For certain brands of frames or other eyewear on which the manufacturer does not allow discounts. Or for services and supplies when combined with any other offer, coupon or in-store advertisement.

- **Vision Materials.** Vision Materials other than Safety Eyewear required as a condition of employment. Including, but not limited to, eyeglass lenses, contact lenses, frames and upgrades to eyeglass lenses, contact lenses and frames.

Member Payment Responsibility

Your Out-of-Pocket Costs

You may have to pay a portion of the cost for covered services. *Copays* are an example of an out-of-pocket cost. Your out-of-pocket costs may vary depending on whether you receive vision care from a *participating* or *non-participating provider*. See the section How to Access Your Services and Obtain Approval for Benefits for more information on *providers*. Keep reading to learn about your out-of-pocket costs.

Benefit Maximums, Allowances and Frequency Limits

Maximum Allowable Amount. The *maximum allowable amount* is the most we will pay for *covered services*. It is based on our established network fee schedule. *Participating providers* have agreed to accept the *maximum allowable amount* as payment in full for *covered services*. You may be responsible to pay for a portion of the *maximum allowable amount*, such as your *copayment*. Your portion of the *maximum allowable amount* is stated in the Schedule of Benefits. *Non-participating providers* have not agreed to accept our *maximum allowable amount* as payment in full and may charge you their usual amount for services and supplies.

Allowances/Reimbursement Amounts. You may have an allowance or reimbursement amount to apply to services or supplies under this *plan*. This means you will have a set dollar amount to use toward the service or supply. If the service or supply costs more than the allowance or reimbursement, you will be responsible to pay for the difference. Allowances and reimbursement amounts are stated in the Schedule of Benefits.

When you use an allowance or reimbursement amount at a *non-participating provider*, you will be responsible to pay for all charges at the time of service. You will then need to submit a claim to us to obtain the allowance or reimbursement. See the Claims Procedure section in this *certificate* for more information.

Benefit Frequency Limits. The benefit frequency limit is the number of times we will pay for a *covered service* within a stated benefit period. You are responsible to pay all charges for services or supplies that are received more than the allowed frequency limits. Benefit frequencies are stated in the Schedule of Benefits.

Claims Procedure (How to File a Claim)

This section describes how you submit a claim and what information you should include on your claim. When you receive care from a *participating provider*, you do not need to file a claim. The *participating provider* will do this for you. However, if you receive vision care from a *non-participating provider*, you will need to submit a claim to us.

Notice of Claim. After you receive vision care you will need to contact us, either by phone or mail (see contact information listed below). You should contact us within 20 days of the date you received vision care so we can provide you with the claim forms for filing. Notice given by someone on your behalf, or to any agent authorized by us, within information to identify you will be deemed notice to us. If you are unable to contact us within 20 days, it does not mean we will not pay for your claim. Just contact us as soon as reasonably possible.

Claim Forms. We will provide claim forms within 15 days after you notify us. The claim form will have instructions on how to fill it out and where to submit. If you do not receive a claim form within 15 days of your claim notice, you may send us other written proof of claim instead. An example of other proof of claim would be an itemized bill from your provider. To make it easier to process your claim, the other proof of claim should include the following:

- the date of service.
- the patient's name, date of birth, and identification number.
- the type and place of service.
- your signature and the provider's signature.

Proof of Claim. Your written proof of claim (such as the claim form or an itemized bill) should be provided to us within 90 days after the date of you received vision care. If it is not reasonably possible to provide your written proof of loss within this time, we will not invalidate or reduce your claim. However, you must send it as soon as reasonably possible, and in no event later than a year from when it was due, unless you are legally incapacitated.

Notice of claim, claim forms and itemized bills can be sent to the following address:

Anthem Blue View Vision
PO Box 8504
Mason, Ohio 45040-7111
Phone: (866) 723-0515

Time of Payment of Claims. We will generally pay claims within 30 days after we receive your proper, complete and written proof of your claim.

Payment of Claims. We will pay claims directly to *providers* if they have an assignment of benefits on file. If the *provider* does not have an assignment of benefits on file then we will pay claims to you or your designated beneficiary.

General Provisions

Fraudulent Insurance Acts. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a subscriber or claimant for the purpose of defrauding or attempting to defraud the subscriber or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Entire Contract. Your *plan* is the entire contract of insurance. Your *plan* is made up of this certificate, the group contract, the group application, your application and any riders, endorsements or amendments. No agent has the authority to change this plan or waive any of its provisions. An executive officer must endorse any change that we issue for it to be valid. All statements made by you or your group shall be deemed representations and not warranties. No written statement made by you will be used in any contest for a claim unless a copy of the statement is furnished to you, or to your beneficiary or personal representative.

Incontestability. The validity of this *plan* will not be contested, except for nonpayment of *premiums*, after it has been in force for two years from its date of issue. No statement made by you or your *dependents* relating to you or your ***dependent's*** insurability will be used to contest the validity of this *certificate* unless the statement is contained in a written instrument signed by your or your *dependents*.

Vision Examination. We may have you examined as reasonably needed while we are deciding to pay a claim. Such examination would be at our expense. Your will be notified in advance of any such examination.

Change of Beneficiary. You have the right to choose your own beneficiary.

Independent Contractors. Providers are not our agents or employees. They do not have the ability to waive or alter your *plan*. We are not responsible for any damages or injuries as a result of receiving care from any *provider*.

Right of Recovery. When we overpay a claim, we have the right to recover our overpayment. We may recover our overpayment from you, the person we paid, or another plan. We may deduct any overpayment from pending or future claims.

Benefits not Transferable, You are the only person able to receive benefits under this *plan*. You are not able to transfer your benefits to anyone else.

Continuation of Care. If a *participating provider's* contract terminates with us, we shall continue to pay for covered services received from that provider for 60 days if you are under their care. The provider will also provide you care for 60 days in accordance with this *plan* unless your care is assumed by another *participating provider*.

Coordination of Benefits. We consider this *plan* primary in all circumstances.

Conformity with State Law. The laws of the State of Colorado will be used to interpret any part of this *plan*. Any provision of this *plan* which is in conflict with the laws of the State of Colorado will be amended to conform to the minimum requirements of such laws.

Notice of Privacy Practices. We maintain a privacy program designed to protect your health information consistent with applicable law. In additional to various laws governing your privacy, we have our own privacy policies and procedures in place that are designed to protect your information.

We are required by law to provide individuals with notice of our legal duties and privacy practices. To obtain a copy of this notice, call us or visit the website listed in the Contact Us section of this *certificate*.

Vision Services. We are not liable for providing *covered services*, but merely for the payment of them. You will have no claim against us for any acts or omissions of a *provider* that you receive *covered services* from. We have no responsibility if a *provider* fails or refuses to give *covered services* to you.

Statement of ERISA Rights. Your group plan may be part of an employee welfare benefit plan governed by the Employee Retirement Income Security Act (ERISA). If your group plan is governed by ERISA, then you are entitled to the following:

- Your group must allow you to see all documents that govern this plan. This includes a copy of the latest annual report that we filed with the U.S. Department of Labor. You can view these documents at no charge at your group office or some other location that you and the group agree to.

- You can, through a written request to your group, get copies of the documents that govern this plan. This includes copies of the latest annual report and an updated summary plan description. Your group may charge you a reasonable fee for the copies; and.

- Your group is required by law to give each member a copy of the summary annual report

ERISA also makes rules for the people who are responsible for the operations of your plan. These people are called "fiduciaries" of the plan. They have a duty to operate this plan in a reasonable way that is in your interest. No one, including your employer, can fire you or discriminate against you, to prevent you from getting a welfare benefit. Also, they cannot prevent you from using your rights under ERISA.

If you submit a claim and it is denied or ignored, you have a right to know why. You have a right to get copies of the documents that relate to the decision in your claim. These documents must be provided to you at no charge. You also have the right to appeal the decision in your claim. To make an appeal, you must follow the process that is stated in the “Appeals and Complaints” section.

Under ERISA, there are steps you can take to enforce your rights. For example, if you ask for a copy of plan documents or the latest annual report and the group does not give them you within 30 days, you may file suit in a Federal court. The court may require the group to give you the documents and pay you up to $110 a day until you receive the documents. If you have a claim that was denied or ignored, you may file suit in a state or Federal court. However, you can only file suit after you have gone through the appeals and complaints process in this booklet. If the plan fiduciaries misuse the plan's money, or if you are discriminated against because you have enforced your ERISA rights, you should contact the U.S. Department of Labor. You may also file suit in a Federal court. If you file suit, the court will decide who should pay court costs and legal fees. If you win your case, the court may order the other party (or parties) to pay these costs and fees. If you do not win your case, the court may order you to pay the costs and fees.

Questions about ERISA. If you have any questions about your plan and whether or not the ERISA rules apply to your plan, contact your group. If you have any questions about your ERISA rights or if you need help getting documents from your group, contact the nearest office of the Pension and Welfare Benefits Administration. The Pension and Welfare Benefits Administration is a part of the U.S. Department of Labor. They are listed in the phone directory. You can also contact them at the following address:

Division of Technical Assistance and Inquiries
Pension and Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210.

You can also get more information about ERISA rights and responsibilities by calling the publications hotline of the Pension and Welfare Benefits Administration.

We give the group or other fiduciaries the authority to determine eligibility for coverage. The group or other fiduciaries also have the authority to interpret the terms of this plan. The group and other fiduciaries must do these things in a reasonable way and within the limits of any state or federal laws.

Termination / Nonrenewal / Continuation

Termination

This section tells you how your coverage may end. Unless otherwise stated in this section, written notice of cancellation or nonrenewal will be delivered to your *group* within 30 days of the cancellation. Except as noted below, coverage will end on the last day of the month in which the event occurs.

If Your Group Cancels or Does Not Renew Coverage. Upon the group contract's plan anniversary date, this coverage will renew at the option of the group. If your *group* cancels decides to not renew or otherwise cancels this plan, your coverage will end on the date the *group contract* between us and your *group* ends.

If You Cancel Your Coverage. If you want to cancel your or your *dependent's* coverage you need to tell your *group*. See your *group's* human resources or benefits department for more information on how to cancel your coverage. If you cancel, your *group* will be responsible to notify us in writing of the cancellation and to tell us what date your coverage will end.

Upon the Subscriber's Death. If the *subscriber* dies, coverage under this *plan* will end. *Dependents* may seek coverage under COBRA.

If Your Group Does Not Pay the Premium. Your group must pay us any premium due on your behalf. We must receive the *premium* no later than the end of the grace period for your coverage to remain in force. If your *group* does not pay your premium by the end of your grace period we may cancel your coverage. See the Reinstatement provision later in this section for information on reinstating coverage if it lapses due to premiums not being paid.

If You Fail to Pay the Premium. If you fail to pay your portion of the Premium, coverage will end as of the last date for which premium was paid.

If You or Your Dependents are no Longer Eligible. Coverage will end if you or your dependents no longer meet the eligibility requirements of this *plan*. See the Eligibility section for information on eligibility requirements. If you (the *subscriber*) lose coverage because you are no longer eligible, your *dependents* will also lose coverage. Your *group* determines the date your coverage ends once you lose eligibility. See your *group's* human resources or benefits department for more information.

Mistakes and Fraudulent Misstatements. If you or your group made mistakes on your application we may void your *plan* or deny claims if we discover it during the first two years of your coverage. We will not void your *plan* or deny claims for mistakes we discover after two years. If you or your group made fraudulent misstatements on your application we may void this *plan* or deny claims at any time.

Fraud. If you or your *dependents* knowingly engage in any fraud or misuse of the benefits in this booklet, we will cancel your coverage.

Non-Renewal of Your Plan. We may at any time decide to not renew this *plan*. If this happens we will give the *group* notice 90 days before we non-renew this *plan*.

We Cease to Offer this Coverage. If we stop offering this plan in the group market, we will cancel your coverage in accordance with the terms and conditions of the laws of the State of Colorado. We will promptly refund any unearned *premium*.

Continuation of Coverage

COBRA Continuation. Your employer is subject to COBRA if they have more than 20 employees. COBRA allows you and your dependents to continue coverage for either 18, 29 or 36 months depending on the event.

COBRA coverage is available to you and your dependents for 18 months for the following events:

- You lose coverage due to a reduction in working hours, a layoff, or strike.
- You lose coverage because your employment ends. (For voluntary or involuntary loss, except for gross misconduct).

COBRA coverage is available to you and your dependents for 29 months for the following events:

- You or your dependent was disabled when coverage ended or within 60 days after the coverage ended. However, you or your dependent must continue to be disabled after 18 months has passed. The Social Security Administration must determine if you are disabled.

COBRA coverage is available to your dependents for 36 months for the following events:

- Your death.
- You become eligible for Medicare in the 18 months before an event listed above.
- You divorce or separate from your spouse.
- Your dependent children no longer qualify as dependents.

You must notify your employer within 60 days if you or your dependents wish to continue coverage under COBRA after an event. Once notified, your employer will provide the information on how coverage under COBRA may continue, and must give us notice within 30 days of the event that you wish to continue coverage. Contact your employer for more information.

How State Continuation or COBRA Ends. Your state or COBRA continuation coverage ends when the time period that you qualified for runs out. However, coverage may end before that time if one of the following occurs:

- The group contract between us and the employer ends. If your employer switches coverage you will be able to continue coverage under their new plan.
- You fail to pay the premium.
- You tell us in writing to cancel your coverage.
- The date your spouse remarries and becomes eligible under the new spouse's plan.

Coverage may also end for State Continuation if the following occurs:

- You are eligible for coverage with another group. However, if your State Continuation plan covers something that the other group doesn't then you may continue coverage. Your coverage will continue until the group covers that exclusion or you are no longer eligible.

Coverage may also end for COBRA if the following occurs:

- You are eligible for coverage with another group. However, if your COBRA plan covers something that the other group doesn't then you may continue coverage. Your coverage will continue until the group covers that exclusion or you are no longer eligible.

- You get Medicare

- Your coverage was extended to 29 months and you are now no longer disabled.

Conversion Coverage. Conversion is not available under this certificate.

Military Service. If you are going into or coming back from military service, you and your dependents may continue coverage under this plan. These rights apply only if you and your dependents were covered under this plan before you leave for military service.

If you keep this coverage for you or your dependents, you may be asked to pay up to 102% of your normal premium. But if you are on active duty for 30 days or less, you cannot be asked to pay more than your normal premium.

The maximum time of coverage under this provision is the lesser of:

- 24 months, starting on the date when your absence from work begins.

- Until you return to work. If you do not return to work, your coverage will end the day after you were supposed to apply for or return to work.

When you return to work there will not be any limits or waiting periods to reinstate your coverage, as long as there were none before your military service. But there may be limits or waiting periods if you have any illness or injury that the Secretary of Veterans Affairs finds to have been as a result of your service.

Appeals and Complaints

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem or question about your plan or a service you have received. In those cases, please contact member services by calling the number in the Contact Us section of this booklet. We will try to resolve your complain informally by talking to your provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a Grievance or Appeal. Keep reading for more information.

We may have turned down your claim. We may have also denied your request to preauthorize a service. If you disagree with our decision you can:

1. file a complaint
2. file an appeal or
3. file a grievance.

Complaints

If you want to start a complaint about our member services or how we processed your claim, please call us. A trained staff member will try to clear up any confusion about the matter. They will also try to resolve your complaint. If you prefer, you can send a written complaint to this address:

Anthem Blue Cross and Blue Shield
Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111

If your complaint is not solved either by writing or calling, or if you do not want to file a complaint, you can file an appeal. We will tell you how to do that next, in the Appeals section.

> **Note:** More details on the complaints and appeals processes and time periods can be found in the Appeals Guide. You may get a copy of the Appeals Guide by visiting www.anthem.com or you can call member services.

Appeals

If we have denied a claim that you feel should have been covered or handled in a different way you can file an appeal. If we cancelled your coverage retroactive for a reason that is not because the premiums were not paid, you can file an appeal. You can appeal a denial that was made by us before the service is received. You can also appeal a denial on a service after it is received. You may also appeal and eligibility determination made by us.

While we encourage you to file your appeal within 60 days of the unfavorable benefit determination, the written or oral appeal must be received by us within 180 days of the unfavorable benefit determination.. You will assign an employee to help you in the appeal process. An appeal can be filed verbally by calling member services at the Contact Us section.

An appeal can be filed in writing to this address:

Anthem Blue Cross and Blue Shield
Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111

You do not have to start a complaint before you file an appeal. In your appeal, please state as plainly as possible why you think we should not have denied your claim. Include any documents you did not submit with the original claim or service/supply request. Also send any other document or documents that support your appeal.

You do not have to file the appeal yourself. Someone else, like your *provider* or another representative of your choice, can file any level of appeal for you. Just let us know in writing who will be filing the appeal for you.

Internal Appeals. We have an internal process that we follow when reviewing your appeal. Members of our staff who were not involved when your claim was first denied will review the appeal. They may also talk with other co-workers to assist in the review.

If your first internal appeal is denied, you can ask for a second level appeal. But you do not have to file a second level appeal with us before requesting an independent external review appeal or pursuing legal action.

Expedited Internal Appeals. If you have an urgent case you may request that your internal appeal to be reviewed in a shorter time period. This is called an expedited internal appeal. You or your representative can ask for an expedited appeal if you had emergency services but have not been discharged from the facility. Also, you can ask for an expedited appeal if the regular appeal schedule would do one of the following:

- Seriously jeopardize your life or health.
- Jeopardize your ability to regain maximum function.
- Create an immediate and substantial limitation on your ability to live independently, if you are disabled.
- In the opinion of a physician with knowledge of your condition, would subject you to severe pain that ca not be adequately managed without the service in question.

Grievances

If you have an issue or concern about the quality or services you receive from a *network provider* or facility, you can file a grievance. The quality management department strives to resolve grievances fairly and quickly. You may call member services or send a written grievance to:

Anthem Blue Cross and Blue Shield
Blue View Vision
P.O. Box 8504
Mason, OH 45040-7111

Our quality management department will acknowledge that we have received your grievance. They will also investigate it. We treat every grievance confidentially.

Division of Insurance Inquiries. If you have a question about health care coverage in Colorado, please call the Division of Insurance at (303) 894-7490. Representatives will speak with you Monday through Friday, from 8:00 a.m. to 5:00 p.m. You can also write to:

The Division of Insurance
Attention ICARE Section
560 Broadway, Suite 850
Denver, Colorado 80202.

Binding Arbitration. The binding arbitration provision under this Booklet is applicable to claims arising under all individual plans, governmental plans, church plans, plans or claims to which ERISA preemption does not apply, and plans maintained outside the United States. Any such arbitration will be governed by the procedures and rules established by the American Arbitration Association. You may obtain a copy of the Rules of Arbitration by calling our customer services. The law of the state in which the policy was issued and delivered to you shall govern the dispute.

The arbitration decision is binding on both you and us. Judgment on the award made in arbitration may be enforced in any court with proper jurisdiction. If any person subject to this arbitration clause initiates legal action of any kind, the other party may apply for a court of competent jurisdiction to enjoin, stay or dismiss any such action and direct the parties to arbitrate in accordance with this section.

Legal Action. Before you take legal action on a claim decision, you must first follow the complaints and appeals process as outlined in this *certificate*. You must meet all the requirements of this *plan*. If the law requires, and if you have exhausted all mandatory levels of review as defined in this *certificate*, you can also have the claim decision reviewed de novo (as if for the first time) in any court with jurisdiction and to a trial by jury. No action in law or in equity shall be brought to recover on this *plan* prior to expiration of 60 calendar days after a claim has been filed according to the requirements of this *certificate*. If you have exhausted all mandatory levels of review in your appeal, you may be entitled to have the claim decision review de novo (as if for the first time) in any court with jurisdiction and to a trial by jury. No such action shall be brought at all unless brought within three years after the claim has been filed as required by this *certificate*.

Information on Plan and Premium Changes

This section explains how and for what reasons that we may change the plan and the premium.

Changes to Your Plan. We may change this plan, including the premiums, at any time by providing notice to the *group* at least 30 days before the change takes effect.

Changes to the Premium. Premiums are the monthly charges your group must pay us for to keep this coverage in effect. We determine out and set the required premiums. Your group is responsible for paying your premium to us according to the terms of the group contract. You may be required to pay a portion of the premium. See your *group's* human resources or benefits department for more information.

We may change your premiums on your *group's* renewal date for this *plan*. If wrong information is given to us that we use to establish your premium, then the difference will billed to the *group*.

Grace Period. Your *group* is responsible to pay premiums on your behalf. After the first premium payment, your *group* has a grace period of 31 days to pay any premium due. During the grace period, your coverage will continue in force unless your employer has given us written notice to cancel the coverage in accordance with the terms of the *group contract*.

Definitions

The meanings of key terms used in this certificate are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in your certificate, you should refer to this section.

Benefit Period. The period of time that benefit maximums and frequencies are tracked. See the Schedule of Benefits for your benefit period and the allowed benefit maximums and frequencies.

Certificate. This booklet, which is a summary of your *plan's* coverage. It is attached to and is a part of the *group contract*, and is subject to the terms and conditions of the *group contract*.

Coinsurance. The percentage of the *plan's maximum allowable* amount for which you are responsible to pay for *covered services*. See the Schedule of Benefits for your coinsurance amounts.

Copayment (or copay). A fixed dollar amount that you are responsible to pay for *covered services*. See the Schedule of Benefits for your copayment amounts.

Covered Service. Services, supplies or treatments that are listed as covered in this *certificate*. A covered service is incurred on the date the service, supply or treatment was provided to you. To be considered a covered services, the service must be:

- within the scope of the license of the *provider* performing the service.
- rendered while coverage under this *certificate* is in force.
- within the *maximum allowable amount*.
- not specifically excluded or limited by the *certificate*.
- specifically listed as a benefit within this *certificate*.

Deductible. The amount you have to pay out-of-pocket for *covered services* before we begin to pay.

Dependent. A person of the *subscriber's* family who is eligible for coverage under the *plan* as described in the Eligibility section of this *certificate*.

Effective Date. The date your coverage begins. Your effective date is listed on your ID card.

Group. The employer that has entered into a *group contract* with the *plan***.**

Group Contract (or Contract). The contract between Anthem and the *group*. It includes this *certificate*, your and the *group's* applications, and any endorsements or riders.

Last Date of Service. The period of time that benefit maximums and frequencies are tracked. When you get a covered service, you must wait a period of time from the last date of service before you get the covered service again. See the Summary of Benefits for the benefit frequencies allowed.

Maximum Allowable Amount. The maximum allowable amount is the maximum amount we pay for *covered services*. It is based on our established network fee schedule. See the Member Payment Responsibility section for more information on the maximum allowable amount.

Member. A *subscriber* or *dependent* who has satisfied the eligibility requirements of the *group*, applied for coverage, been accepted by us for coverage, and for whom *premiums* have been paid.

Non-Participating Provider. A vision care provider who has not entered into a contractual agreement with us for the network associated with this *plan*.

Participating Provider. A vision care provider who has entered into a contractual agreement with us for the network associated with this *plan*. They also accept our payment plus your cost-share as payment in full for *covered services*.

Plan. The entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this booklet, your and your group's application, any amendments, endorsements or riders, and the *group contract*.

Premium. The periodic charges that the *group* must pay us to maintain coverage under this *plan*. You may be responsible to pay a portion of the premium. See your *group* for more information on this.

Provider. A duly licensed person or facility that provides services within the scope of an applicable license.

Subscriber. The employee or other member of the *group* whose enrollment application has been accepted by us for coverage under this *plan*. Subscriber eligibility requirements are determined by the *group*.

Get Help In Your Language

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Amharic

ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።

(TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD:711).

Bassa

M̀ ɓéɖé dyí-ɓèɖèìn-ɖèɔ ɓé m̀ ké bɔ̌ nìà kɛ kè gbo-kpá- kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Đá méɓà jè gbo-gmɔ̀ Kpòè nɔɓà nìà nì Dyí-dyoìn-bɛ̃̀ɔ̃ kɔ̃ɛ ɓé m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German

Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Igbo

Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Nepali

तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्।(TTY/TDD: 711)

Oromo

Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yoruba

O ní ẹtọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.