Vision Blue℠

GOLD

For plan years beginning January 1, 2023 or later

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OVERVIEW OF THE PLAN

The following provisions of this booklet contain a summary in English of your rights and benefits under the plan. If you have questions about your benefits, please contact our Customer Service Department at 1-800-877-7195. If needed, simply request a translator and one will be provided to assist you in understanding your benefits.

Las siguientes disposiciones de este folleto contienen un resumen en inglés de sus derechos y beneficios bajo el plan. Si usted tiene preguntas acerca de sus beneficios, por favor póngase en contacto con nuestro Departamento de Servicio al Cliente al 1-800-877-7195. Si es necesario, basta con solicitar un traductor de español y se le proporcionará uno para ayudarle a entender sus beneficios.

Purpose of the Plan

The plan is a stand-alone vision plan. The plan is intended to help you and your covered dependents pay for the costs of vision care. The plan does not pay for all of your vision care. For example, you may be required to contribute through payroll deduction before you obtain coverage under the plan. You may also be required to pay copayments.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.

Using *my*BlueCross to Get More Information

By being a member of the plan, you get exclusive access to ***my*BlueCross** – an online service only for members. Use it to easily manage your healthcare coverage. All you have to do is register at www.AlabamaBlue.com/Register. With ***my*BlueCross**, you have 24-hour access to personalized healthcare information, PLUS easy-to-use online tools that can help you save time and efficiently manage your healthcare:

- Download and print your benefit booklet.
- Easily navigate to VSP.com to login and access:
  - Your vision ID card
  - Your claims history
  - Find a doctor.

Definitions

Near the end of this booklet you will find a section called Definitions, which identifies words and phrases that have specialized or particular meanings. In order to make this booklet more readable, we generally do not use initial capitalized letters to denote defined terms. Please take the time to familiarize yourself with these definitions so that you will understand your benefits.

Receipt of Vision Care

Even if the plan does not provide benefits, you and your provider may decide that care and treatment are necessary. You and your provider are responsible for making this decision.

Beginning of Coverage

The section of this booklet called Eligibility will tell you what is required for you to be covered under the plan and when your coverage begins.

Limitations and Exclusions

The plan contains a number of provisions that limit or exclude benefits for certain services and supplies, even if visually necessary. You need to be aware of these limits and exclusions in order to take maximum advantage of this plan.

Vision Necessity

The plan will only pay for care that is visually necessary. The definitions of visual necessity are found in the Definitions section of this booklet.

In-Network Benefits

One way in which the plan tries to manage vision care costs and provide enhanced vision benefits is through negotiated discounts with in-network doctors. In-network doctors are providers that have agreed to participate in the Choice Network. **Preferred Providers** are in-network doctors in and out of the state of Alabama.

Assuming the services are covered, you will normally only be responsible for any applicable copayments, non-covered services or materials, or amounts which exceed plan allowances. If you receive covered services or supplies from an out-of-network doctor, in most cases, you may be responsible for paying for all services and/or materials in full and submitting a claim for any applicable reimbursement. Obtaining services from an out-of-network doctor will typically result in higher out of pocket expenses because these out-of-network doctors can bill you amounts in excess of the allowable amounts under the plan.

To locate in-network doctors, go to VSP.com and select “Find a Doctor.”

Search tip: Look for the orange banner representing the VSP Premier Program. All members have access to the Premier Program, which is part of the network of highly knowledgeable doctors. Network doctors who participate in the Premier Program provide the personalized attention you want and the ease you need.

Relationship Between Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Alabama is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Alabama. Blue Cross and Blue Shield of Alabama is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than Blue Cross and Blue Shield of Alabama and your employer will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Alabama not created under the original agreement.

Claims and Appeals

When you receive services from in-network doctors, your doctor will generally file claims for you. In other cases, you may be required to pay the provider and then file a claim for reimbursement under the terms of the plan. If a claim is denied in whole or in part, you may file an appeal. You will be given a full and fair review. The provisions of the plan dealing with claims or appeals are found further on in this booklet.

Changes in the Plan

From time to time it may be necessary for us to change the terms of the plan. The rules for changing the terms of the plan are described later in the section called Changes in the Plan.

Termination of Coverage

The section below called Eligibility tells you when coverage will terminate under the plan. If coverage terminates, no benefits will be provided thereafter, even if for a condition that began before the plan or your coverage termination. In some cases you will have the opportunity to buy COBRA coverage after your group coverage terminates. COBRA coverage is explained in detail later in this booklet.

Respecting Your Privacy

To administer this plan we need your medical information from physicians, hospitals and others. To decide if your claim should be paid or denied or whether other parties are legally responsible for some or all of your expenses, we need records from healthcare providers and other plan administrators. By applying for coverage and participating in this plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need in order to administer this plan or to perform any function authorized or permitted by law. You further direct all other persons to release all records to us about your minor dependents that we need to administer the plan If you or any provider refuses to provide records, information or evidence we request within reason, we may deny your benefit payments. You also agree that we may call you at any telephone number provided to us by you, your employer, or any healthcare provider in accordance with applicable law. Additionally, we may use or disclose your personal health information for treatment, payment or healthcare operations, or as permitted or authorized by law pursuant to the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We have prepared a privacy notice that explains our obligations and your rights under the HIPAA privacy regulations. To request a copy of our notice or to receive more information about our privacy practices or your rights, please contact us at the following address:

Blue Cross and Blue Shield of Alabama
Privacy Office
P.O. Box 2643
Birmingham, Alabama 35202-2643

You may also go to www.AlabamaBlue.com for a copy of our privacy notice.

Your Rights

As a member of the plan, you have the right to:

- Receive information about us, our services, in-network providers, and your rights and responsibilities.

- Be treated with respect and recognition of your dignity and your right to privacy.
- Participate with providers in making decisions about your healthcare.
- A candid discussion of appropriate or visually necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about us, or the healthcare the plan provides.
- Make recommendations regarding our member rights and responsibilities policy.

If you would like to voice a complaint, please call the Customer Service Department at 1-800-877-7195.

Your Responsibilities

As a member of the plan, you have the responsibility to:

- Supply information (to the extent possible) that we need for payment of your care and your providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your providers and verify through the benefit booklet provided to you the coverage or lack thereof under your plan.
- Understand your vision problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

ELIGIBILITY

Eligibility for the Plan

You are eligible to enroll in this plan if all of the following requirements are satisfied:

- You are an employee and are treated as such by your group. Examples of persons who are not employees include independent contractors, board members, and consultants;
- Your group has determined that you work on average 30 or more hours per week (including vacation and certain leaves of absence that are discussed in the section dealing with termination of coverage);
- You are in a category or classification of employees that is covered by the plan;
- You meet any additional eligibility or participation rules established by your group; and,
- You satisfy any applicable enrollment waiting period, as explained below.

You must continue to meet these eligibility conditions for the duration of your participation in the plan.

Enrollment Waiting Periods

There may be an enrollment waiting period under the plan, as determined by your group. You should contact your group to determine if this is the case. Your group will also tell you the length of any applicable enrollment waiting period.

Coverage will begin on the date specified below under Beginning of Coverage.

Applying for Plan Coverage

Fill out an application form completely and give it to your group. You must name all eligible dependents to be covered on the application. Your group will collect all of the employees'

applications and send them to us. Some employers provide for electronic online enrollment. Check with your group to see if this option is available.

Eligible Dependents

Your eligible dependents are:

- Your spouse;
- Your married or unmarried child up to age 26; and,
- Your unmarried, incapacitated child who (1) is age 26 and over; (2) is not able to support himself; and (3) depends on you for support, if the incapacity occurred before age 26.

The child may be the employee's natural child; stepchild; legally adopted child; child placed for adoption; or eligible foster child. An eligible foster child is a child that is placed with you by an authorized placement agency or by court order.

You may cover your grandchild only if you are eligible to claim your grandchild as a dependent on your federal income tax return.

Beginning of Coverage

Annual Open Enrollment Period

If you do not enroll during a regular enrollment period or a special enrollment period described below, you may enroll only during your group's annual open enrollment period (generally, 30 days before the beginning of each plan year). Your coverage will begin on the first day of the plan year following such annual open enrollment period in which you enroll.

Regular Enrollment Period

If you apply within 30 days after the date on which you meet the plan's eligibility requirements (including any applicable enrollment waiting periods established by your group), your coverage will begin as of the date thereafter specified by your group. If you are a new employee, coverage will not begin earlier than the first day on which you report to active duty.

Special Enrollment Period for Individuals Losing Other Vision Coverage

An employee or dependent (1) who does not enroll during the first 30 days of eligibility because the employee or dependent has other vision coverage, (2) whose other vision coverage was either COBRA coverage that was exhausted or coverage by other vision plans which ended due to "loss of eligibility" (as described below) or failure of the employer to pay toward that coverage, and (3) who requests enrollment within 30 days of the exhaustion or termination of coverage, may enroll in the plan. Coverage will be effective no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment.

Loss of eligibility with respect to a special enrollment period includes loss of coverage as a result of legal separation, divorce, cessation of dependent status, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility that is measured by reference to any of these events, but does not include loss of coverage due to failure to timely pay premiums or termination of coverage for fraud or misrepresentation of a material fact. Loss of eligibility with respect to a special enrollment period also includes a situation where an individual incurs a claim that would meet or exceed a lifetime limit on all plan benefits.

Special Enrollment Period for Newly Acquired Dependents

If you are already enrolled and have a new dependent as a result of marriage, birth, placement

for adoption, adoption, or placement as an eligible foster child, you may enroll your spouse and your new dependent provided that you request enrollment within 30 days of the event. The effective date of coverage will be the date of birth, placement for adoption, adoption, or placement as an eligible foster child. In the case of a dependent acquired through marriage, the effective date will be no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment.

If we accept your application, you will receive an identification card. If we decline your application, all the law requires us to do is refund any fees paid.

Qualified Medical Child Support Orders

If the group (the plan administrator) receives an order from a court or administrative agency directing the plan to cover a child, the group will determine whether the order is a Qualified Medical Child Support Order (QMCSO). A QMCSO is a qualified order from a court or administrative agency directing the plan to cover the employee's child regardless of whether the employee has enrolled the child for coverage. The group has adopted procedures for determining whether such an order is a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting your group.

The plan will cover an employee's child if required to do so by a QMCSO. If the group determines that an order is a QMCSO, we will enroll the child for coverage effective as of a date specified by the group, but not earlier than the later of the following:

- If we receive a copy of the order within 30 days of the date on which it was entered, along with instructions from the group to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which the order was entered.
- If we receive a copy of the order later than 30 days after the date on which it was entered, along with instructions from the group to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which we receive the order. We will not provide retroactive coverage in this instance.

Coverage may continue for the period specified in the order up to the time the child ceases to satisfy the definition of an eligible dependent. If the employee is required to pay extra to cover the child, the group may increase the employee's payroll deductions. During the period the child is covered under the plan as a result of a QMCSO, all plan provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law. For example, a child covered by a QMCSO may be subject to a pre-existing condition exclusion.

While the QMCSO is in effect we will make benefit payments – other than payments to providers to the parent or legal guardian who has been awarded custody of the child. We will also provide sufficient information and forms to the child's custodial parent or legal guardian to allow the child to enroll in the plan. We will also send claims reports directly to the child's custodial parent or legal guardian.

Termination of Coverage

Plan coverage ends as a result of the first to occur of the following (generally, coverage will continue to the end of the month in which the event occurs):

- The date on which the employee fails to satisfy the conditions for eligibility to participate in the plan, such as termination of employment or reduction in hours (except during vacation or as otherwise provided in the Leaves of Absence rules below);
- For spouses, the date of divorce or other termination of marriage;

- For children, the first day following the end of the plan year in which a child ceases to be a dependent;
- For the employee and his or her dependents, the date of the employee's death;
- Your group fails to pay us the amount due within 30 days after the day due;
- Upon discovery of fraud or intentional misrepresentation of a material fact by you or your group;
- When none of your group's members still live, reside or work in Alabama; or,
- On 30-days advance written notice from your group to us.

In all cases except the last item above, the termination occurs automatically and without notice. All the dates of termination assume that payment for coverage for you and all other employees in the proper amount has been made to that date. If it has not, termination will occur back to the date for which coverage was last paid.

Leaves of Absence

If your group is covered by the Family and Medical Leave Act of 1993 (FMLA), you may retain your coverage under the plan during an FMLA leave, provided that you continue to pay your premiums. In general, the FMLA applies to employers who employ 50 or more employees. You should contact your group to determine whether a leave qualifies as FMLA leave.

You may also continue your coverage under the plan for up to 30 days during an employer-approved leave of absence, including sick leave. Contact your group to determine whether such leaves of absence are offered. If your leave of absence also qualifies as FMLA leave, your 30-day leave time runs concurrently with your FMLA leave. This means that you will not be permitted to continue coverage during your 30-day leave time in addition to your FMLA leave.

If you are on military leave covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, you should see your group for information about your rights to continue coverage under the plan.

COST SHARING

Covered Services and Materials

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Exams:		
WellVision Exam® one per member every 12 months	$10 copayment	Covered up to $45 after a $10 copayment
Contact Lens – fitting & evaluation one per member every 12 months	Not to exceed $60 copayment	See out-of-network Materials - Elective Contact Lenses
Routine Retinal Screening	Not to exceed $39 copayment	Not covered
Materials:		
Materials (frames & lenses)	$20 copayment	See below
Retail Frame one per member every 12 months	Covered up to $150	Reimbursed up to $70 after materials copayment

Elective Contact Lenses (instead of glasses) one per member every 12 months	Covered up to $150, not subject to copayment	Reimbursed up to $105 for both materials and fitting/evaluation not subject to copayment
Necessary Contact Lenses one per member every 12 months	Covered in full after $20 copayment	Reimbursed up to $210 after materials copayment
Lenses:		
Single Vision one per member every 12 months	100% after materials copayment	Reimbursed up to $30 after materials copayment
Lined Bifocal one per member every 12 months	100% after materials copayment	Reimbursed up to $50 after materials copayment
Lined Trifocal one per member every 12 months	100% after materials copayment	Reimbursed up to $65 after materials copayment
Lenticular one per member every 12 months	100% after materials copayment	Reimbursed up to $100 after materials copayment
Lens Enhancements:		
Polycarbonate for Children one per member every 12 months	100% after materials copayment	Not covered
Standard Progressives Plastic one per member every 12 months	100% after materials copayment	Reimbursed up to $50 after materials copayment

Value Added Programs

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Essential Medical Eye Care	$20 copayment per medical eye examination	Not Covered
Low Vision *Testing every 2 years*	Supplemental Testing covered in full, Includes evaluation, diagnosis and prescription of vision aids where indicated. **Supplemental Aids**:75% of VSP Preferred Provider's Fee, up to $1,000 Maximum benefit for all Low Vision services and materials is $1,000 every two (2) years and a maximum of two supplemental tests within a two-year period.	

The Supplemental Essential Medical Eye Care benefit is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the benefit, eye care professionals provide treatment and services for urgent ocular emergencies as well as the management of chronic systemic diseases that manifest in the eyes.

Essential Medical Eye Care benefits are available to members only after all other benefits under their group medical plan have been exhausted, or when member is not covered under a group medical plan.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Network Provider. Professional services for severe visual problems that cannot be corrected with regular lenses.

COORDINATION OF BENEFITS (COB)

Members who are covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). The Plan will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under the member's Vision Blue Plan, which may reduce or eliminate the member's out-of-pocket expense. Members covered under more than one Vision Blue Plan may also be able to take advantage of COB. In order to process claims involving COB, the Plan may need to share personal information regarding members with other parties (such as another insurance company). When this is necessary, the Plan will only share such information with those

persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

VISION BENEFIT EXCLUSIONS

We will not provide benefits for the following:

A

Vision services primarily for **appearance**.

B

Vision services to the extent coverage is available to the member under any other **Blue Cross and Blue Shield contract.**

C

Vision services for which you are not **charged.**

Services or expenses for which a **claim** is not properly submitted.

Services or expenses of any kind either (a) for which a **claim** submitted for a member has not been received, or (b) for which a claim is received later than 24 months after the date services were performed.

Services or expenses of any kind for **complications** resulting from services received that are not covered as benefits under this contract.

E

Vision services you receive before your **effective date of coverage**, or after your effective date of termination.

F

Charges to use any **facility** such as a hospital in which vision services are rendered, whether the use of such a facility was medically necessary.

Charges for your **failure** to keep a scheduled visit with the doctor.

Some brands of spectacle **frames** and/or lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Members may obtain details regarding frame and lens brand availability from their Plan Member Doctor or by calling Customer Service at (800) 877-7195.

L

Services or expenses covered in whole or in part under the **laws** of the United States, any state, county, city, town or other governmental agency that provide or pay for care, through insurance or any other means. This applies even if the law does not cover all your expenses.

Contact **lens modification**, polishing or cleaning.

Replacement of lenses, frames and/or contact lenses furnished under this Plan which are **lost or damaged,** except at the normal intervals when Plan Benefits are otherwise available.

M

Medications or supplies of any type.

P

Charges for vision care or treatment by a **person** other than the attending doctor unless the treatment is rendered under the direct supervision of the attending doctor.

Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the Light Care enhancement, if purchased by Client.

R

Refitting of contact lenses after the initial (90-day) fitting period.

T

Local, state and/or federal **taxes**, except where the plan is required by law to pay.

Two pair of glasses instead of bifocals.

V

Vision care or treatment not specifically identified as a covered vision expense.

Services or expenses we determine are not **visually necessary** or for which do not meet generally accepted standards of vision practice. This means vision procedures that are considered strictly cosmetic in nature are not covered.

CLAIMS AND APPEALS

This section of your booklet explains how vision claims process and how you can appeal a partial or complete denial of a claim. Remember that you may always call the Customer Service Department for help if you have a question or problem that you would like to fix without an appeal.

The claims and appeal procedures are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Even if your plan is not covered by ERISA, we will process your claim according to ERISA's standards and provide you with the ERISA appeal rights that are discussed in this section of your booklet.

HOLD HARMLESS

Members shall be held harmless for any sums owed by the plan to the Preferred Provider, other than those sums not covered by the Plan.

COMPLAINTS AND GRIEVANCES

Members have the right to expect quality care from Preferred Providers. More information is available

under “Patient’s Rights and Responsibilities” on VSP’s web site at www.vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Members may submit any complaints and/or grievances, including appeals, in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or verbally by calling the Customer Service Department at 1-800-877-7195. The plan will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) calendar days after the plan’s receipt of the complaint or grievance. If the plan determines that resolution cannot be achieved within thirty (30) days, the plan will notify the Member of the expected resolution date. Upon final resolution, the Plan will notify the Member of the outcome in writing.

CLAIM PAYMENTS AND DENIALS

Initial Determination: The plan will pay or deny claims within thirty (30) calendar days of receipt. In the event that a claim cannot be resolved within the time indicated the plan, may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Claim Denial Appeals: If a claim is denied in whole or in part, under the terms of the Policy, Member or Member’s authorized representative may submit a request for a full review of the denial. Member may designate any person, including their provider, as their authorized representative. References in this section to “Member” include Member’s authorized representative, where applicable.

Initial Appeal: The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Member affected by the denial. The Member may review, during normal working hours, any documents held by the plan pertinent to the denial. The Member may also submit written comments or supporting documentation concerning the claim to assist in the plan’s review. The plan’s response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Member within thirty (30) calendar days after receipt of a request for an appeal from the Member.

Second Level Appeal: If Member disagrees with the response to the initial appeal of the denied claim, Member has the right to a second level appeal. Within sixty (60) calendar days after receipt of the plan’s response to the initial appeal, Member may submit a second appeal to the plan along with any pertinent documentation. The plan shall communicate its final determination to the Member in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies: When the Member has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. The Member may contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], the Member has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed, the claims were not approved in whole or in part, and the Member disagrees with the outcome.

Time of Action: No action in law or in equity shall be brought to recover on the Policy prior to the Member exhausting his/her grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable documentation have been filed with the plan. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of the Policy

COBRA COVERAGE

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title

X). If COBRA applies, you may be able to temporarily continue coverage under the plan beyond the point at which coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA coverage may be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of a qualifying event. You are not entitled to buy COBRA coverage if you are employed as a nonresident alien who received no U.S. source income, nor may your family members buy COBRA.

Not all group vision plans are covered by COBRA. As a general rule, COBRA applies to all employer sponsored group vision plans (other than church plans) if the employer employed 20 or more full or part-time employees on at least 50% of its typical business days during the preceding calendar year. In determining the number of employees of an employer for purposes of COBRA, certain related corporations (parent/subsidiary and brother/sister corporations) must be treated as one employer. Special rules may also apply if the employer participates in an association plan.

You must contact your employer to determine whether this plan is covered by COBRA. Blue Cross is not your plan administrator.

By law, COBRA benefits are required to be the same as those made available to similarly situated active employees. If the group changes the plan coverage, coverage will also change for you. You will have to pay for COBRA coverage. Your cost will equal the full cost of the coverage plus a two percent administrative fee. Your cost may change over time, as the cost of benefits under the plan changes. If the group stops providing vision care through Blue Cross, Blue Cross will stop administering your COBRA benefits. You should contact your group to determine if you have further rights under COBRA.

COBRA Rights for Covered Employees

If you are a covered employee, you will become a qualified beneficiary if you lose coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

COBRA coverage will continue for up to a total of 18 months from the date of your termination of employment or reduction in hours, assuming you pay your premiums on time. If, apart from COBRA, your group continues to provide coverage to you after your termination of employment or reduction in hours (regardless of whether such extended coverage is permitted under the terms of the plan), the extended coverage you receive will ordinarily reduce the time period over which you may buy COBRA benefits.

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to buy COBRA coverage. The period of your COBRA coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your group that you do not intend to return to work, whichever occurs first.

COBRA Rights for a Covered Spouse or Dependent Children

If you are covered under the plan as a spouse or a dependent child of a covered employee, you will become a qualified beneficiary if you would otherwise lose coverage under the plan as a result of any of the following events:

- The covered employee dies;
- The covered employee's hours of employment are reduced;

- The covered employee's employment ends for any reason other than his or her gross misconduct;
- The covered employee becomes enrolled in Medicare;
- Divorce of the covered employee and spouse; or,
- For a dependent child, the dependent child loses dependent child status under the plan.

When the qualifying event is a divorce or a child losing dependent status under the plan, you must timely notify the plan administrator of the qualifying event. You must provide this notice within 60 days of the event or within 60 days of the date on which coverage would be lost because of the event, whichever is later. See the section called Notice Procedures for more information about the notice procedures you must use to give this notice.

If you are a covered spouse or dependent child, the period of COBRA coverage will generally last up to a total of 18 months in the case of a termination of employment or reduction in hours and up to a total of 36 months in the case of other qualifying events, provided that premiums are paid on time. If, however, the covered employee became enrolled in Medicare before the end of his or her employment or reduction in hours, COBRA coverage for the covered spouse and dependent children will continue for up to 36 months from the date of Medicare enrollment or 18 months from the date of termination of employment or reduction in hours, whichever period ends last.

If you are a child of the covered employee or former employee and you are receiving benefits under the plan pursuant to a qualified medical child support order, you are entitled to the same rights under COBRA as a dependent child of the covered employee.

If your coverage is canceled in anticipation of divorce and a divorce later occurs, the divorce may be a qualifying event even though you actually lost coverage under the plan earlier. If you timely notify the plan administrator of your divorce and can establish that your coverage was canceled in anticipation of divorce, COBRA coverage may be available to you beginning on the date of your divorce (but not for the period between the date your coverage ended and the date of the divorce).

Extension of COBRA for Disability

If you or a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and you timely notify the plan administrator, the 18-month period of COBRA coverage for the disabled person may be extended to up to 11 additional months (for a total of up to 29 months) or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself. The 29-month period will run from the date of the termination of employment or reduction in hours. For this disability extension to apply, the disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

The cost for COBRA coverage after the 18th month will be 150% of the full cost of coverage under the plan, assuming that the disabled person elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

For a spouse and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. See the following discussion under "Extensions of COBRA for Second Qualifying Events" for more information about this.

For this disability extension of COBRA coverage to apply, you must give the plan administrator timely notice of Social Security's disability determination before the end of the 18-month period of

COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event, (2) the date on which coverage would be lost because of the initial qualifying event, or (3) the date of Social Security's determination. You must also notify the plan administrator within 30 days of any revocation of Social Security disability benefits. See the section called Notice Procedures for more information about the notice procedures you must use to give this notice.

Extensions of COBRA for Second Qualifying Events

For a spouse and children receiving COBRA coverage, the 18-month period may be extended to 36 months if another qualifying event occurs during the 18-month period, if you give the plan administrator timely notice of the second qualifying event. The 36-month period will run from the date of the termination of employment or reduction in hours.

This extension is available to a spouse and children receiving COBRA coverage if the covered employee or former employee dies, becomes enrolled in Medicare, or gets divorced, or if the child stops being eligible under the plan as a dependent child, *but only if the event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred.* For example, if a covered employee is terminated from employment, elects family coverage under COBRA, and then later enrolls in Medicare, this second event will rarely be a second qualifying event that would entitle the spouse and children to extended COBRA coverage. This is so because, for almost all plans that are subject to COBRA, this event would not cause the spouse or dependent children to lose coverage under the plan if the covered employee had not been terminated from employment.

For this 18-month extension to apply, you must give the plan administrator timely notice of the second qualifying event within 60 days after the event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later. See the section called Notice Procedures for more information about the notice procedures you must use to give this notice.

Notice Procedures

If you do not follow these notice procedures or if you do not give the plan administrator notice within the required 60-day notice period, you will not be entitled to COBRA or an extension of COBRA as a result of an initial qualifying event of divorce or loss of dependent child status, a second qualifying event or Social Security's disability determination.

Any notices of initial qualifying events of divorce or loss of dependent child status, second qualifying events or Social Security disability determinations that you give must be in writing. Your notice must be received by the plan administrator or its designee no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period.

For your notice of an initial qualifying event that is a divorce or a child losing dependent status under the plan and for your notice of a second qualifying event, you must mail or hand-deliver your notice to the plan administrator. If the initial or second qualifying event is a divorce, your notice must include a copy of the divorce decree. For your convenience, you may ask the plan administrator for a free copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

For your notice of Social Security's disability determination, if you are instructed to send your COBRA premiums to Blue Cross, you must mail or hand-deliver your notice to Blue Cross at the following address: Blue Cross and Blue Shield of Alabama, Attention: Customer Accounts, 450 Riverchase Parkway East, Birmingham, Alabama 35244-0001, or fax your notice to Blue Cross at 205-220-6884 or 1-888-810-6884 (toll-free). If you do not send your COBRA premiums to Blue Cross, you must mail or hand-deliver your notice to the plan administrator. Your notice must also include a copy of Social Security's disability determination. For your convenience, you may ask

the plan administrator for a free copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

Adding New Dependents to COBRA Coverage

You may add new dependents to your COBRA coverage under the circumstances permitted under the plan. Except as explained below, any new dependents that you add to your COBRA coverage will not have independent COBRA rights. This means, for example, that if you die, they will not be able to continue coverage.

If you are the covered employee and you acquire a child by birth or placement for adoption while you are receiving COBRA coverage, then your new child will have independent COBRA rights. This means that if you die, for example, your child may elect to continue receiving COBRA benefits for up to 36 months from the date on which your COBRA benefits began.

If your new child is disabled within the 60-day period beginning on the date of birth or placement of adoption, the child may elect coverage under the disability extension if you timely notify the plan administrator of Social Security's disability determination as explained above.

Electing COBRA

After the plan administrator receives timely notice that a qualifying event has occurred, the plan administrator is responsible for (1) notifying you that you have the option to buy COBRA, and (2), sending you an application to buy COBRA coverage.

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage under the plan, or (2), the date on which the group notifies you that you have the option to buy COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children. An election to buy COBRA coverage will be considered made on the date sent back to the group.

Once the group has notified us that your coverage under the plan has ceased, we will retroactively terminate your coverage and rescind payment of all claims incurred after the date coverage ceased. If you elect to buy COBRA during the 60-day election period, and if your premiums are paid on time, we will retroactively reinstate your coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time your coverage under the plan ends and the time we learn of your loss of coverage, it is possible that we may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the plan. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time.

COBRA Premiums

Your first COBRA premium payment must be made no later than 45 days after you elect COBRA coverage. That payment must include all premiums owed from the date on which COBRA coverage began. This means that your first premium could be larger than the monthly premium that you will be required to pay going forward. You are responsible for making sure the amount of your first payment is correct. You may contact the plan administrator to confirm the correct amount of your first payment.

After you make your first payment for COBRA coverage, you must make periodic payments for each subsequent coverage period. Each of these periodic payments is due on the first day of the month for that coverage period. There is a grace period of 30-days for all premium payments

after the first payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, any claim you submit for benefits will be suspended as of the first day of the coverage period and then processed by the plan only when the periodic payment is received. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA coverage under the plan.

Payment of your COBRA premiums is deemed made on the day sent.

Early Termination of COBRA

Your COBRA coverage will terminate early if any of the following events occur:

- The group no longer provides group vision coverage to any of its employees;
- You do not pay the premium for your continuation coverage on time;
- After electing COBRA coverage, you become covered under another group vision plan;
- After electing COBRA coverage, you become enrolled in a Medicare plan with vision coverage; or,
- You are covered under the additional 11-month disability extension and there has been a final determination that the disabled person is no longer disabled for Social Security purposes.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the plan. For example, if you submit fraudulent claims, your coverage will terminate.

If your group stops providing vision care through Blue Cross, you will cease to receive any benefits through us for any and all claims incurred after the effective date of termination of our contract with the group. This is true even if we have been billing your COBRA premiums prior to the date of termination. It is the responsibility of your group, not Blue Cross, to notify you of this termination. You must contact your group directly to determine what arrangements, if any, your group has made for the continuation of your COBRA benefits.

When COBRA Coverage Ends

If you exhaust your COBRA coverage or you stop paying for it, then you will not have any further coverage under the group vision plan.

If you have any further questions about COBRA or if you change marital status, or you or your spouse or child changes address, please contact your plan administrator. Additional information about COBRA can also be found at the web site of the Employee Benefits Security Administration of the United States Department of Labor.

GENERAL INFORMATION

Delegation of Discretionary Authority to Blue Cross

The group has delegated to us the discretionary responsibility and authority to determine claims under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with our provision of benefits and/or administrative services under the plan.

Whenever we make reasonable determinations that are neither arbitrary nor capricious in our administration of the plan, those determinations will be final and binding on you, subject only to

your right of review under the plan (including, when applicable, arbitration) and thereafter to judicial review to determine whether our determination was arbitrary or capricious (in the case of claims covered by Section 502(a) of ERISA) or correct using the standard of review set forth in any applicable arbitration provisions of this booklet.

Notice

We give you notice when we mail it or send it electronically to you or your group at the latest address we have. You and your group are assumed to receive notice three days after we mail it. Your group is your agent to receive notices from us about the plan. The group is responsible for giving you all notices from us. We are not responsible if your group fails to do so.

Unless otherwise specified in this booklet, if you are required to provide notice to us, you should do so in writing, including your full name and contract number, and mail the notice to us at 450 Riverchase Parkway East, P.O. Box 995, Birmingham, Alabama 35298-0001.

Responsibility for Providers

We are not responsible for what providers do or fail to do. If they refuse to treat you or give you poor or dangerous care, we are not responsible. We need not do anything to enable them to treat you.

Misrepresentation

If you commit fraud or make any intentional material misrepresentation in applying for coverage, when we learn of this we may terminate your coverage back to the effective date on which your coverage began as listed in our records. We need not refund any payment for your coverage. If your group commits fraud or makes an intentional material misrepresentation in its application, it will be as though the plan never took effect, and we need not refund any payment for any member.

Governing Law

The law governing the plan and all rights and obligations related to the plan shall be ERISA, to the extent applicable. To the extent ERISA is not applicable, the plan and all rights and obligations related to the plan shall be governed by, and construed in accordance with, the laws of the state of Alabama, without regard to any conflicts of law principles or other laws that would result in the applicability of other state laws to the plan.

Termination of Benefits and Termination of the Plan

Our obligation to provide or administer benefits under the plan may be terminated at any time by either the group or us by giving written notice to the other as provided for in the contract. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

If the group fails to pay us the amounts due under the contract within the time period specified therein, our obligation to provide or administer benefits under the plan will terminate automatically and without notice to you or the group as of the date due for payment. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

Subject to any conditions or restrictions in our contract with the group, the group may terminate the plan at any time through action by its authorized officers. In the event of termination of the plan, all benefit payments by us will cease as of the effective date of termination, regardless of

whether notice of the termination has been provided to you by the group or us. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

If for any reason our services are terminated under the contract, you will cease to receive any benefits by us for any and all claims incurred after the effective date of termination. In some cases, this may mean retroactive cancellation by us of your plan benefits. This is true for active contract holders, retirees, COBRA beneficiaries and dependents of either. Any fiduciary obligation to notify you of our termination belongs to the group, not to us.

Changes in the Plan

By giving a 30-day notice to the group, we may amend any and all provisions of the plan or the amount of fees that you or your group must pay for coverage under the plan. The fiduciary obligation to notify you of these changes belongs to the group, not us. The plan amendment will be effective whether or not the group has notified you of the amendment. Payment of premiums by the group after the effective date of the amendment will constitute acceptance by you and the group of the changes.

Except as otherwise provided in the contract, no representative or employee of Blue Cross is authorized to amend or vary the terms and conditions of the plan or to make any agreement or promise not specifically contained in the plan documents or to waive any provision of the plan documents. This means, in part, that no representative, employee, or agent of Blue Cross may make any changes to the plan over the telephone or verbally.

No Assignment

As discussed in more detail in the Claims and Appeals section of this booklet, most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call the Customer Service Department and ask for a claim form. However, regardless of who files a claim for benefits under the plan, we will not honor an assignment by you of payment of your claim to anyone. What this means is that we will pay covered benefits to you or your in-network provider (as required by our contract with your in-network provider) – even if you have assigned payment of your claim to someone else. With out-of-network providers, we may choose whether to pay you or the provider.
When we pay you or your provider, this completes our obligation to you under the plan. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our plan obligation to you.

Alabama Insurance Fraud Investigation Unit and Criminal Prevention Act

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

DEFINITIONS

Allowable Amount: The amount of a doctor's charge that Blue Cross will recognize as covered expenses for medically/visually necessary services provided by the plan. This amount is generally limited to the lesser of the doctor's charge for care or the fee for a procedure in the in-network doctor's fee schedule. In-network doctors normally accept this allowable amount (subject to any applicable copayments that are the responsibility of the patient) as payment in

full for covered services. Out-of-network providers may bill the member for charges in excess of the allowable amount.

Blue Cross: Blue Cross and Blue Shield of Alabama, except where the context designates otherwise.

Contract: Unless the context requires otherwise, the terms "contract" and "plan" are used interchangeably. The contract includes our financial agreement or administrative services agreement with the group.

Eyecare Professional: Any duly licensed optometrist (O.D.), ophthalmologist or other doctor of medicine (M.D.), or doctor of osteopathy (D.O.).

Group: The employer or other organization that has contracted with us to provide or administer group vision benefits pursuant to the plan.

In-Network Preferred Provider: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with the Plan to Plan Benefits on behalf of members under the plan.

Member: You or your eligible dependent who has coverage under the plan.

Out-of-Network Doctor: Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted to provide vision care services and/or vision care materials to members under the plan.

Plan: The plan is the group vision benefit plan of the group, as amended from time to time. The plan documents consist of the following:

- This benefit booklet, as amended;
- Our contract with the group, as amended;
- Any benefit matrices upon which we have relied with respect to the administration of the plan; and,
- Any draft benefit booklets that we are treating as operative. By "operative," we mean that we have provided a draft of the booklet to the group that will serve as the primary, but not the sole, instrument upon which we base our administration of the plan, without regard to whether the group finalizes the booklet or distributes it to the plan's members.

If there is any conflict between any of the foregoing documents, we will resolve that conflict in a manner that best reflects the intent of the group and us as of the date on which claims were incurred. Unless the context requires otherwise, the terms "plan" and "contract" have the same meaning.

Plan Administrator: The group that sponsors the plan and is responsible for its overall administration. If the plan is covered under ERISA, the group referred to in this definition is the "administrator" and "sponsor" of the plan within the meaning of section 3(16) of ERISA.

Visually Necessary or Vision Necessity: Services and materials which are necessary to restore or maintain your visual acuity and eye health or to treat your injury or visual symptom. To be visually necessary, services or materials must be:

- Appropriate and necessary for the symptoms, diagnosis, treatment or correction of your visual acuity or vision condition;
- Provided for the diagnosis or direct care and treatment of your vision condition;
- In accordance with ophthalmologic/optometric practice industry standards;
- Not primarily for the convenience and/or comfort of you, your family, your doctor, or

another provider of services;

- Not "investigational."

We, Us, Our: Blue Cross and Blue Shield of Alabama.

You, Your: The contract holder or member as shown by the context.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation, to the extent applicable to the plan. As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. You are entitled to receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Vision Plan Coverage

Continue vision coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this booklet plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your group, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan administrator and do not receive them within 30 days, you may file suit in a Federal court (unless

your plan has a binding arbitration clause). In such a case, the court may require the plan administrator, which is not Blue Cross, to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after you have exhausted your administrative remedies under the plan. In addition, if you disagree with the plan administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Administrative Information

To comply with ERISA's technical requirements for a summary plan description, your group must furnish the following information: name of the plan; name and address of the group; name, address and telephone number of the plan sponsor and the plan administrator; employer identification number (EIN) from the IRS; and name and address of the plan's agent for legal purposes.

Blue Cross provides you with the following information:

- The plan year ends twelve (12) months from the effective date of the contract.
- The plan sponsor and plan administrator is the group. The group is responsible for discharging all obligations that ERISA and its regulations impose upon plan sponsors and plan administrators, such as delivering summary plan descriptions, annual reports, and COBRA notices when required by law.
- The plan provides vision benefits as administered under the contract between Blue Cross and Blue Shield of Alabama and the group. Blue Cross has complete discretion to interpret and administer the provisions of the plan. The administrative functions performed by Blue Cross include paying claims, determining visual necessity, etc. The plan benefits are underwritten.
- The group currently intends to continue the plan as described herein, but reserves the right, in its discretion, to amend, reduce or terminate the plan and coverage at any time for active employees, retirees, former employees, and all dependents.

This is an employer-employee shared cost plan. The sources of the contributions to this plan are

currently the group and the employee in relative amounts as determined by the group from time to time. Any information concerning what is to be paid by the employee in the future will be furnished by the group in writing and will constitute a part of this plan. Your contribution is determined by the group based on the plan's experience and other factors.

NOTICE OF NONDISCRIMINATION

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have 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 or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

FOREIGN LANGUAGE ASSISTANCE

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-216-3144 (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل **1-855-216-3144** بـ (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કોલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144（TTY: 711）まで、お電話にてご連絡ください。

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