



A Guide to Your Benefits

*You've made a good decision in choosing
Blue View Vision Exclusive Plan*

Independent licensees of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks of Blue Cross and Blue Shield Association.

Blue View Vision

Schedule of Benefits

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.

| Vision Care Services | Benefit Frequency | In-Network | Out-of-Network |
|---------------------------------------|-----------------------|------------|----------------|
| Eye Exam (with dilation as necessary) | Once every 12 months* | \$20 copay | Up to \$35 |

*From last date of service

Welcome

Thank you for selecting the CU Health Plan as your insurance provider. By choosing this plan, you're backed by a team dedicated to providing you with the best health coverage possible and helping you save money at a time when healthcare costs are rising. You're committed to your vision health, and so are we.

If you're reading this, you're probably looking for information on how your plan works. You have enrolled in a health benefit plan that, pursuant to the terms of this booklet, pays for many of your health care expenses, including most expenses for physician and outpatient care, emergency care and hospital inpatient care.

This plan is self-funded by the University of Colorado Health and Welfare Trust. That means all of the claims you make will be paid by the trust, which is funded by contributions from you and other subscribers at the University of Colorado and CU Medicine. Anthem provides administrative services only, including provider network contracting, member services, pharmacy benefits management, care management, and other administrative support.

This booklet is a guide to your plan. Please review this document to become familiar with your benefits, including their limitations and exclusions. Keep it in a convenient place for quick reference when you need it. By learning how your coverage works, you'll be able to make the best healthcare decisions possible and take advantage of all the great benefits available to you.

For questions about coverage or how benefits are administered, please visit BeColorado.org or call Anthem's Member Services department. The toll-free Member Services department number is located on your Health Benefit ID Card.

Thank you for selecting the CU Health Plan for your healthcare needs. We wish you good health.



Tony DeCrosta
Chief Plan Administrator
University of Colorado Health and Welfare Trust

Contact us

Member services

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

Visit us on-line

www.anthem.com

Hours of operation

Monday - Saturday

5:30 a.m. to 8:00 p.m. MST

Sunday

8:00 a.m. to 5:00 p.m. MST

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Eligibility

This section explains when your coverage begins and who is eligible for coverage. It also explains your effective date and where to find that information. Keep reading this section to learn about eligibility requirements and your effective date. Refer to the "Termination / Nonrenewal" section for how your coverage ends.

Who is Eligible for Coverage

Your Eligible Dependents

You (the *subscriber*) have coverage under this booklet because of your employer. You may enroll your eligible *dependents* for coverage under this *plan*. Your *dependents* are only eligible for coverage if they are one of the following:

- **Spouse:** As defined by your Employer.
- **Child:** A Subscriber's son, daughter, stepson, stepdaughter or eligible foster child, including a legally adopted individual or an individual who is lawfully placed with the Subscriber for legal adoption, or a child for whom the Subscriber has established parental responsibility (as evidenced by court documents), may be covered under the terms of this Booklet through the end of the calendar month in which the child turns 27. There may be tax consequences to the Subscriber when enrolling his or her child or a partner's child through the calendar month in which the child turns age 27. A Dependent child of a Subscriber who is no longer eligible for coverage may be eligible for continuation coverage. Information can be found under the heading Continuation of Benefits in this section of this Booklet.
- **Disabled Child.** A disabled child may continue to be covered under this *plan* if we receive notice of the disability. 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 child's physician must fill out a disabled dependent form and provide it to us. Contact us to obtain the form.

Newborn and Adopted Dependent Coverage

We provide automatic coverage to a newborn *child* or an adopted *child* (under 18 years of age) for 31 days. For a newborn *child* coverage begins on the date of birth. For an adopted child coverage begins on the date you assume or retain a legal obligation to support the *child*.

You must add the newborn *child* or adopted *child* to your *plan* within 31 days for coverage to continue beyond 31 days. You must contact us to obtain the necessary forms.

Notice of Changes in Eligibility

You must tell your employer and us if there are any changes that will affect your or your *dependent's* eligibility. You must notify us within 31 days of any event that changes your or your *dependents* eligibility. This includes a

change in address, a marriage, or a divorce. If you do not tell us about a change in eligibility, it does not obligate us to pay for vision care.

How to Enroll Your Dependents for Coverage

Open Enrollment

At least once a year your employer will hold an open enrollment period. During the open enrollment period your eligible *dependents* can enroll for coverage.

Special Enrollment

There may be times when your *dependents* can enroll for coverage outside of the open enrollment period. We allow this when there is a change in a dependent status, a court order, or an involuntary loss of other group coverage.

Involuntary Loss of Other Group Coverage

If your *dependents* did not enroll during open enrollment because of other group coverage, they may enroll when that coverage ends. You or your *dependents* must tell us that they want to enroll within 31 days after the other group coverage ends.

Change in Dependent Status

If you have a new *dependent* due to a qualifying event, you may enroll your *dependent* for coverage. A qualifying event is marriage, the birth of a child, or a child placed for adoption. You must enroll your *dependent* within 31 days of the qualifying event.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or other court order to provide coverage to a child, you can enroll the child at any time. You do not have to wait until your employer's open enrollment period.

Your Effective Date

Your coverage begins on your effective date. This is the date we and your employer agreed that your coverage would start. We will strive to mail your welcome letter and ID card to you before your coverage starts. Your effective date will be listed on your welcome letter and will also be printed on your ID card.

How to Access Your Services and Obtain Approval of Benefits

Please read the following information so you will know from whom or what group of providers vision care may be obtained.

Important Note: Neither We nor your employer 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 and Non-Participating Providers

Participating Providers

We have a network of *participating providers* for you to use. We call them “participating” vision care providers because they have agreed to take part in our 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.

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. Using a *non-participating provider* will typically increase your out of pocket costs. Covered Services you receive from a non-participating provider are considered Out-of-Network care.

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

Benefits / Coverage

Benefit Maximums and Allowances

The amount we pay, on behalf of your employer, for your benefits is subject to your benefit maximums and allowances. We and your employer will not pay for vision care services that go over your benefit maximums or allowances as stated in the schedule of benefits.

Conditions of Service

The following conditions of service must be met for vision care services to be considered a *covered service*.

1. You must receive vision care while you are covered for benefits under this *plan*. Vision care is incurred on the date you receive the service for which the charge is made.
2. The vision care must be provided by a licensed optometrist, ophthalmologist, or optician.
3. The vision care must be for a vision service that is included under "Vision Care That is Covered".
4. The vision care must not be for a service or supply listed under "Vision Care That is NOT Covered". If the service or supply is partially excluded, then only that portion which is not excluded will be considered a *covered service*.
5. The vision care must not exceed any of the benefits maximums, allowances or limitations of this *plan*.

Vision Care that is Covered

The following services or supplies are covered subject to our Conditions of Service. We, on behalf of the employer, will only pay for vision care that is listed in this section. We will not pay for vision care listed in the "Vision Care that is not Covered" section.

Eye Exam

Your plan covers a complete eye exam with dilation as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together. An eye exam does not include a contact lens fitting fee.

Limitations / Exclusions

Vision Care That is NOT Covered

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

- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a member receives the benefits in whole or in part. This exclusion also applies whether or not the member claims the benefits or compensation. It also applies whether or not the member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the member's immediate family, including the member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Booklet or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a network provider).
- For sunglasses and accompanying frames.
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Booklet.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- For frames, glasses lenses or contact lenses.
- For upgrades to frames, glasses lenses or contact lenses.

Member Payment Responsibility

This section tells you how we set the payment amount for vision care and also what your cost share is. Our payment on behalf of the employer for vision care to *participating* and *non-participating providers* is based on our *maximum allowable amount*. Your cost share will differ depending on your choice of vision care provider.

The 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.

In-Network

For covered services received In-Network, the maximum allowable amount is equal to the network provider's agreement for this product.

Out-of-Network

For covered services received Out-of-Network, the maximum allowable amount is the lesser of the actual charge or the rate under the network provider's agreement for this product. We will pay up to the amount listed in the schedule of benefits.

Your Cost Share Requirements

Your Cost Share

You may be required to pay a part of the *maximum allowable amount* for *covered services*. This is called your cost share amount. *Copays* or *deductibles* are examples of a cost share amount.

Your cost share amount will vary depending on whether you receive vision care from a *participating* or *non-participating provider*. You may be required to pay higher cost sharing amounts when using *non-participating providers*.

We will not provide payment for vision care that is not covered by your *plan*. You are required to pay all charges for vision care that is not covered. Vision care received after you have met benefit maximums is also not covered.

Authorized Services

In some situations, we may authorize the participating cost share amounts 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 cost share amount may even apply if you do not contact us in advance.

If we authorize the participating cost share for vision care from a *non-participating provider*, you are still responsible for the difference between our *maximum allowable amount* and the billed amount.

Claims Procedure

You are responsible for getting claims filed after you receive vision care. However, if you receive vision care from a *participating provider* they will typically file claims on your behalf.

If you receive care from a *non-participating provider* you must submit the claim to us

After you receive vision care you will need to contact us, either by phone or mail, within 20 days of your vision care so we can provide you claim forms for filing. If you are unable to contact us within 20 days, you should contact us as soon as possible. We will provide claim forms within 15 days for you to file. The claim form will have instructions on how to fill it out and where to mail it.

We must receive the claim form within 90 days from the date you had your vision care. If you are not able to send the claim within 90 days we will not void or reduce your claim. However, you must send it as soon as possible, and in no event no later than a year from when it was due unless you are legally incapacitated.

If you do not receive a claim form within 15 days after you request one, you may send us an itemized bill instead. The itemized bill must include all of 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.

Please send claims and itemized bills to the following address:

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

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 - changes: Your *plan* is the entire contract of insurance. Your *plan* is made up of any attached paper and any amendments that we issue. An executive officer must endorse any change that we issue for it to be valid. No agent has authority to change this *plan* or to waive any of its provisions.

Time of payment of claims: We will pay claims promptly once we receive written proof of your claim as outlined under our claims procedure.

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. If you pass away, we will pay claims to your designated beneficiary or to your estate if there is no assignment of benefits.

Physical examinations: We may have you examined as reasonably needed while we are deciding to pay a claim.

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 them.

Right of Recovery: When we, on behalf of the employer, 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.

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*.

Contracting Entity: You acknowledge that you understand that the *plan* constitutes a contract solely between you and your employer. We are an independent corporation operating under a license from the Blue Cross and Blue Shield Association, which is 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 Mark, and in doing so, we are not contracting as the agent of the Blue Cross and Blue Shield Association. You further acknowledge and agree that you have not entered into the contract based on representations by any person other than one of our representatives, and that no person, entity or organization other than your employer will be held accountable or liable to you for any obligations created under the booklet. This paragraph does not create any additional obligations whatsoever on our part other than those obligations created under other provisions of the booklet.

The Plan, on behalf of the employer, shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Provider or in any Provider's facilities.

Neither the Plan nor your employer is responsible for the actual care you receive from any person. This Benefit Booklet does not give anyone any claim, right, or cause of action against the Plan or your employer based on what a Provider of vision care, services or supplies, does or does not do.

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

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 to 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

This section explains how your coverage may end and your rights regarding reinstatement. Keep reading this section to learn about how your coverage may end. Refer to the “Eligibility” section for your dependent eligibility requirements.

If Your Employer Cancels Coverage

Your coverage will end if your employer cancels coverage or on the date the Employer Master Agreement or Administrative Services Agreement between us and your employer ends.

If You Cancel Your Coverage

If you want to cancel your or your *dependent's* coverage you need to tell us in writing. You may provide the date you would like to cancel your coverage. If you do not provide a cancellation date we will cancel your *plan* on the first day of the next month. We will send you notice of your cancellation date and refund any unused premium.

Upon the Subscriber's Death

If the *subscriber* dies, coverage under this *plan* will end. *Dependents* may seek coverage under COBRA.

If Your Employer Does Not Pay the Premium

We must receive the premium no later than the end of the grace period for your coverage to remain in force. If your employer does not pay your premium by the end of your grace period we may cancel your coverage.

If You or Your Dependents are no Longer Eligible

Your (the *subscriber's*) coverage ends when you no longer meet the terms of the Employer Master Contract or Administrative Services Agreement. Your coverage will end on the first on the month following loss of eligibility.

Your *dependents* coverage will end when they no longer meet the definition of a *dependent*. We will cancel your *dependent's* coverage on the first of the month following the date they lose eligibility. You may also request to remove a *dependent* from your *plan*.

Mistakes and Fraudulent Misstatements

If you or your employer 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 employer 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 you 90 days notice before we non-renew this *plan*.

We Cease to Operate

If we cease operations we will cancel your coverage. We will continue to provide coverage for the rest of the period in which premiums were paid.

Reinstatement of Your Plan

If your *plan* was canceled because you did not pay your premium within the grace period you may have it reinstated. Your *plan* will be reinstated if we accept your premium payment after we have canceled your *plan*. If we accept your premium we will not require an application to reinstate your *plan*.

However, we may ask for a new application to accept your premium and reinstate your *plan*. If we ask for a new application we will only re-instate your *plan* after we approve your application. We will notify you if we do not approve of your application within 45 days. If we do not notify you within 45 after we received your application, it will be deemed approved.

If your *plan* is reinstated, only vision care received after the reinstated date will be covered. Your rights will be the same and will not change due to the reinstatement. We will apply the reinstated premium to the period for which the premium was not paid. However, we will not apply premium to any period over 60 days prior to reinstatement.

United States Military Reserve and National Guard

If you stop your coverage because you are called to active duty, then you may have your coverage reinstated once your active duty is over. Your coverage will be reinstated without any waiting periods. Contact us for info on how to restart your coverage once you end active duty.

How to Continue Coverage

Family and Medical Leave Act

When an employee takes time off from work pursuant to the Family and Medical Leave Act, health insurance benefits remain in force but the employee may be required to continue paying the employee's share of the cost of such health benefits. You may contact your employer for details.

COBRA Continuation Rights Under Federal Law Continuation Coverage For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended and the parallel continuation coverage requirement under the Public Health Service Act ("COBRA"), you and/or your Dependents will be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that Plan's coverage area or the Plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- Your termination of employment for any reason, other than gross misconduct.
- Your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- Your death.
- Your divorce or legal separation.
- Your entitlement to Medicare (Part A, Part B, or both).
- For a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals, who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation. Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension for Your Dependents" are not applicable to these individuals.

The following individuals may not be qualified beneficiaries for purposes of COBRA continuation (unless they meet the federal definition of "qualified beneficiary": partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you), and children of a partner. However, they may be eligible through your employer for continuation coverage under the same time conditions and time periods as COBRA.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; you become entitled to Medicare benefits (under Part A, Part B or both); or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) or the Public Employees' Retirement Association (PERA) Disability Program Administrator to be totally disabled under Title II or XVI of the Social Security Act, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event. To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA/PERA must determine that the disability occurred during the first 60 days after the disabled individual elected COBRA continuation coverage.
- A copy of the written SSA/PERA determination must be provided to the COBRA Plan Administrator within 60 calendar days after the date the SSA/PERA determination is made AND before the end of the initial 18-month continuation period. If the SSA/PERA later determines that the individual is no longer disabled, you must notify the COBRA Plan Administrator within 30 days after the date the final determination is made by SSA/PERA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA/PERA makes a final determination that the disabled individual is no longer disabled. All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA/Continuation Coverage

COBRA/continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA/continuation period of 18, 29 or 36 months, as applicable.
- failure to pay the required premium within 30 calendar days after the due date.
- when the Plan ceases to provide any group health plan, including successor plans to any employee.
- after electing COBRA/continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both); after electing COBRA/continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage. In such case coverage will continue until the earliest of: the end of the applicable maximum period; or the occurrence of an event described in one of the first three bullets above.
- any reason the Plan would terminate coverage of a Member or beneficiary who is not receiving continuation coverage (e.g., fraud).
- You Must Give Notice of Certain Qualifying Events
- If you or your Dependent(s) experience one of the following qualifying events, you must notify the your employer within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:
 - Your divorce or legal separation.
 - Your child ceases to qualify as a Dependent under the Plan.

The occurrence of a secondary qualifying event is discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period). (Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Member covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

COBRA/Continuation for Retirees Following Employer’s or Trust’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to your employer or the Trust under Title 11 of the United States Code, you may be entitled to COBRA/continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Health Coverage Tax Credit (“HCTC”)

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Members who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). The Trade Adjustment Assistance Extension Act of 2011 increased the amount of the HCTC, expanded those eligible to receive it, and extended the COBRA coverage. Eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the HCTC is also available at www.irs.gov by entering the keyword “HCTC.” In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under “Termination of COBRA Continuation” above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify your employer immediately.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

State Continuation

Your employer is subject to the state continuation law if they have less than 20 employees. This law allows you and your dependents to continue coverage for up to 18 months for the following events:

- You (the subscriber) are terminated or have a reduction in working hours resulting in loss of coverage. You must have been covered by the employer's vision insurance for at least 6 consecutive months to qualify.
- Your (the subscriber's) death.
- You and your spouse divorce or become legally separated.
- Your dependents lose coverage under this plan.

You must notify your employer within 30 days if you or your dependents wish to continue coverage after an event. Once notified, your employer will provide the information on how coverage 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.

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 Employer Master Contract or Administrative Services Agreement 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 Booklet.

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; or
- 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 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. start a complaint
2. file an appeal or
3. file a grievance.

Complaints

If you want to start a complaint about our customer service 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
P.O. Box 8504,
Mason, OH 45040-7111

If your complaint isn't solved either by writing or calling, or if you don't want to file a complaint, you can file an appeal. We'll tell you how to do that next, in the Appeals section.

Appeals

It's best to file your appeal within 60 days of getting a denial. The absolute cut-off date for filing an appeal is 180 days from the day you were denied. You can appeal denials that were made either before you received service or after you received service. You can send an appeal in writing to:

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

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

To make sure you get a thorough, unbiased appeal, there are two levels of appeal. Also, if your claim was denied because of utilization review, you may request independent external review.

You don't have to file the appeal yourself. Someone else, like your doctor, can file any level of appeal for you. Just let us know in writing who will be filing the appeal for you.

Level 1 appeal

A Level 1 appeal will be reviewed by a person, who may be on our staff, but who wasn't involved in the denial. They may get information from co-workers or others who did make the decision. Where the decision is based on utilization review, the Level 1 appeal will involve a review by (or a discussion with) a person in the same medical specialty as the case being reviewed.

Unless you ask for or agree to a longer period, you'll get an answer to your appeal within 30 days from when we got your appeal request. But for appeals of services that were already performed, and which did not involve a denial based on utilization review, we'll answer the appeal in 60 days.

Level 2 appeal

If we turned down your appeal at Level 1 you have the choice to continue to a Level 2 appeal. You have 60 days from our Level 1 decision to ask for a Level 2 appeal.

A Level 2 appeal gives you the chance to supply documents or information at an appeal hearing. You can do this in a couple of ways. You can come in person or you can use a teleconference. You are encouraged to bring information, testimony, witnesses or other evidence that supports your appeal.

There will be at least three people who review your appeal. They could be our employees. People who worked on your claim may present information, answer questions, or review the appeal. But a majority of the reviewers will not have worked on your claim before.

If your case involves utilization review, the people reviewing your appeal will be health care professionals. All reviewers:

- Will have appropriate expertise
- Will not have been previously involved in your case; and
- Will not be on our board of directors.
- Will not have a direct financial interest in the case or in the decision.

We will give you a copy of our written decision. We'll also give a copy to any provider who may have represented you in the appeal. You'll get the copy within 60 days from the day we got your Level 2 request, unless you ask for or agree to a longer period.

Expedited appeals

You or your representative can ask for an expedited appeal if you had emergency services but haven't 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're disabled; or
- In the opinion of a physician with knowledge of your condition, would subject you to severe pain that can't be adequately managed without the service in question.

But expedited appeals are not available for denials made after the service has been provided.

Your request doesn't have to be in writing and can be made orally. We'll try to make the decision as soon as we can. But it won't take more than 72 hours. The reviewers won't be the people who denied your claim before. If you don't agree with the appeal decision, you can either continue to a Level 2 appeal, or request independent external review.

Independent external review appeals

For claims based on utilization review, you can request an independent external review appeal. For these appeals, your case is reviewed by an external review entity, selected by the Colorado Division of Insurance.

If you want to request an independent external review, you have to fill out a form. It's called the Request for Independent External Review of Carrier's Final Adverse Determination Form. (Your representative can fill it out for you too.) You can get the form from our customer service department. Once it's filled out, you need to send it to us.

You can ask for an independent external review within 4 months of your receipt of our Level 1 appeal decision, or within 60 days from receipt of the Level 2 appeal decision, or if we fail to complete the Level 1 appeal in the timeframes mentioned above.

Expedited independent external review appeals

You can request an expedited independent external review, but only if your case meets certain criteria. You will need a physician to certify to us that you have a medical condition where following the normal external review appeal process would seriously jeopardize your life or health, would jeopardize your ability to regain maximum function or, if you are disabled, would create an imminent and substantial limitation of your ability to live independently. If it meets these conditions, your request can be filed at the same time as your request for a Level 1 Appeal. Use the external review request form to request an expedited review. An expedited appeal may not be allowed for denials made after service was provided.

Grievances

You may send a written grievance to:

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

Our Member Grievances Department will acknowledge that we've received your grievance. They'll also investigate it. We treat every grievance confidentially.

Binding Arbitration

If the dollar amount of your dispute with Anthem goes above the limit of Small Claims court, then your case will be decided by Binding Arbitration. If it does, you and Anthem give up the right to have the dispute decided in court.

To be arbitrated, a case must first go through all the mandatory levels of appeal and review outlined in this *Booklet*. Arbitration cases are governed by the rules of the American Arbitration Association. Disputes are governed by the laws of the state where the *Booklet* was issued and delivered to the subscriber. Arbitration rulings are binding on you and Anthem. The award can be reviewed and enforced by any court with proper jurisdiction. If anyone starts a lawsuit or other legal action, the other party may ask a court of competent jurisdiction to forbid, stop or dismiss the action and order the parties to follow the arbitration steps presented here. An arbitrator will decide whether any dispute falls under the arbitration clause.

Legal Action

Before you take legal action on a claim decision, you must first follow the complaints and appeals process as outlined in this *Booklet*. 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 *Booklet*, 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 in accordance with the requirements of this *plan*. No such action shall be brought at all unless brought within three years from the date proof of loss is otherwise required

Information on Plan and Premium Changes

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

Changes to Your Plan

We have the right to change any term or condition of your *plan* (including your premiums) at any time. We will provide you 30 days written notice prior to any change to your *plan*.

Changes to Your Premium

Premiums are the monthly charges you and your employer must pay us for coverage and administrative services. We determine and set out the required premiums.

Your employer is responsible for paying your premium to us according to the terms of the Employer Master Contract or Administrative Services Agreement. You may have to help pay the premium cost through payroll deduction. We may change your premiums on the renewal date of your employer. If wrong information is given to us that we use to establish your premium, then the difference will be billed to the employer.

Your employer is entitled to a grace period of 31 days for the payment of such premium. During the grace period, our contract with the employer shall continue in force unless the employer gives us written notice of termination.

Definitions

The meanings of key terms used in this Booklet 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 Booklet, you should refer to this section.

Administrative Services Agreement — the agreement between Anthem Blue Cross and Blue Shield and the employer, regardless of how such an agreement may be titled, stating all the terms and provisions applicable to the administration of this Plan.

Benefit period – is a 12 month period starting on July 1 at 12:01 a.m. Mountain Standard Time.

Booklet – This booklet, which is a summary of your *plan*'s coverage.

Copay – is a fixed dollar amount that you are responsible to pay.

Covered service – is a vision service that is listed in the benefit section of this Booklet.

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

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

Effective date – is the date your coverage begins. Your effective date is listed on your ID card.

Non-participating provider – is a provider who has not entered into a contractual agreement with us for the network associated with this *plan*.

Participating provider – is a 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 – is the entire set of benefits, conditions, exclusions and limitations that make up your coverage. It consists of this booklet, your application, any amendments, the Group Master Application, Administrative Services Agreement and the Employer Master Contract.

Subscriber – is the person whose enrollment application has been accepted by us for coverage under this *plan*.

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 Member Services 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)

Albanian

Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic

ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። እገዛ 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 (TTY/TDD: 711).

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa

M bédédé dyí-bédéíin-dèò bé m kè bʼ nìà kè kè gbo-kpá- kpá dyé dé m bídí-wùdùün bó pídyi. Dá mébà jè gbo-gmò Kpòè nòbà nìà nì Dyí-dyoìn-bèò kòé bé m kè gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali

আপনার বনিমূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।(TTY/TDD: 711)

Burmese

ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရပိုင်ခွင့် သင့်တွင်ရှိပါသည်။
အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။

(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)

Dinka

Yin noŋ yic ba ye lëk në yök ku bë yi kuony në thöŋ yin jām ke cin wëu töu kë piiny. Col rän töŋ də kɔc kë luoi në nām̩ba dën tō në I.D kat du yic. (TTY/TDD: 711)

Dutch

U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstnummer op uw ID-kaart voor ondersteuning. (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)

Greek

Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati

તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા
આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo

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

Ilokano

Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian

Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (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)

Khmer

អ្នកមានសិទ្ធិក្នុងការទទួលបានព័ត៌មាននេះ៖ នឹងទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលបានជំនួយ។ (TTY/TDD: 711)

Kirundi

Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (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)

Samoaan

E iai lou 'aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian

Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (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)

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี
โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ
(TTY/TDD: 711)

Ukrainian

Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu

آپ کو اپنی زبان میں مفت ان معلومات اور مدد کے حصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔ (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)

Yiddish

רופט די מעמבער באדינונגען נומער אויף איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם. (TTY/TDD: 711) אייער קארטל פאר הילף)

Yoruba

O ní ètò láti gba ìwífún yí kí o sì sèrànwọ ní èdè rẹ lófẹ́ẹ. Pe Nọmbà àwọn ìpèsè ọmọ-ẹgbẹ lórí káàdì ìdánimọ rẹ fún ìrànwọ. (TTY/TDD: 711)

It's important we treat you fairly

That's why University of Colorado Health and Welfare Plan follows 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>

The University of Colorado, as Plan Sponsor of the University of Colorado Health and Welfare Plan ("the University"), complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The University does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The University provides free aids and services to people with disabilities to communicate effectively, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). The University also 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 the HIPAA Privacy Officer with CU Health Plan Administration.

If you believe that the University has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

HIPAA Privacy Officer
CU Health Plan Administration
1999 Broadway, Suite 820
Denver, CO 80202
(303) 860-4199
(303) 860-4177 (fax)
cuhealthplan@cu.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the HIPAA Privacy Officer with CU Health Plan Administration 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, 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.