General appeals information

You have the right to review the plan's determination

If you are not satisfied with a decision about your coverage, you are entitled to a review (appeal) of this benefits determination. To obtain a review, you or your authorized representative should submit your request in writing to:

Member Appeals Coordinator
EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040

Your request for a review of this adverse benefit determination must be submitted within 180 days of the date of this Explanation of Benefits.

A copy of the specific rule, guideline, or protocol relied up on in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also review the documents relevant to your claim.

If your plan is governed by ERISA, you may have the right to bring legal action under section 502(a) of ERISA if you do not agree with the final determination on review. You and your plan may have other alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

Centers for Medicare & Medicaid Services

You have the right to appeal our decision

Plan Appeal: Ask EyeMed for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for an appeal with EyeMed" for information on how to ask for a plan level appeal.

Naming someone else to act for you

You can name a relative, friend, attorney, provider or someone else to act as your representative. If you want someone else to act for you, call 877.226.1115 to learn how to name your representative. TTY users call 711. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

Important information about your appeal rights

There are 2 kinds of appeals with EyeMed.

1. **Standard Appeal**: We'll give you a written decision on a standard appeal within **30 days** after we receive your appeal. Our decision might take longer if you ask for an extension, or if we need more information about case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 days**.
2. **Fast Appeal**: We'll give you a decision on a fast appeal within **72 hours** after we receive your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision. **We'll automatically give you a fast appeal if a provider asks for one for you or if your provider supports your request.** If you ask for a fast appeal without support from a provider, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.

How to ask EyeMed for an appeal

1. First, you, your representative, or provider must gather information needed to ask for an appeal. Your request must include:
   - Name
   - Address
   - Member ID number
   - Reason for appealing
   - Any evidence you want us to review, such as medical records, provider letters (such as a provider's supporting statement if you require a fast appeal), or other information that explains why you need the item or service. Call your provider if you need this information.

We recommend keeping a copy of everything you send us for your records. You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

2. Once you've compiled all necessary information, mail, fax or deliver your appeal.

Standard appeals	Fast appeals
EyeMed Vision Care ATTN: Quality Assurance 4000 Luxottica Place Mason, OH 45040 Phone: 877.226.1115 Fax: 513.492.3259 TTY users call: 711 If you ask for a standard appeal by phone, we'll send you a letter confirming what you told us.	Phone: 877.226.1115 TTY users call: 711 Fax: 513.492.3259

What happens next?

If you ask for an appeal and we continue to deny your request for payment of a service, we'll send you a written decision and automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeals rights.**

Get help & more information

- EyeMed toll free: 877.226.1115; TTY users call 711
- Medicare: 1.800.633.4227, 24 hours/7 days a week; TTY users call 1.877.486.2048
- Medicare Rights Center: 1.888.HMO.9050
- Elder Care Locator: 1.800.677.1116 or eldercare.gov to find help in your community.

Appeals by state

State of California

Your request for a review of an adverse benefit determination must be submitted within 180 days of the date of your Explanation of Payment.

A copy of the specific rule, guideline, or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also review the documents relevant to your claim.

You may seek review by the California Department of Insurance of a claim that an insurer has contested or denied by contacting the California Department of Insurance Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, or call the Consumer Hotline at 800.927.HELP (4357), 213.897.8921 for out-of-state callers, TDD at 800.482.4TDD (4833) or online at www.insurance.ca.gov.

You have a right to enter into the dispute resolution process described in Section 10123.13 of Article 1. General Provisions – California Insurance Code.

You may have other alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and the California Department of Insurance.

State of Delaware

You have the right to seek review of our decision regarding the amount of your reimbursement. The Delaware Insurance Department provides claim arbitration services which are in addition to, but do not replace, any other legal or equitable right you may have to review of this decision or any right of review based on your contract with us. You can contact the Delaware Insurance Department for information about arbitration by calling the Arbitration Secretary at 302-674-7322 or by sending an email to: DOIarbitration@state.de.us. All requests for arbitration must be filed within 60 days from the date you receive this notice; otherwise, this decision will be final.

State of Illinois

If you are not satisfied with a coverage decision, you are entitled to a review (appeal) of the benefit determination. To obtain a review, you or your authorized representative should submit your request in writing to:

Member Appeals Coordinator
EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040

Your request for a review of an adverse benefit determination must be submitted within 180 days of the date of your Explanation of Payment.

A copy of the specific rule, guideline, or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also review the documents relevant to your claim.

Notice of Availability: Part 919 of the Rules of the Illinois Department of Insurance requires that our company advise you that, if you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 122 S. Michigan Ave., 19th Floor, Chicago, Illinois 60603 (312-814-2420) and in Springfield at 320 West Washington Street, Springfield, Illinois 62767 (217-782-4515) or contact the Illinois Department of Insurance at http://insurance.illinois.gov/.

You may have other alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and the Illinois Department of Insurance.