Pennsylvania State Employees Credit Union

00501114

Capital Blue Cross Vision

BENEFITS BOOKLET

Administered by:
Capital Blue Cross and Capital Advantage Assurance Company®,
A Subsidiary of Capital Blue Cross
2500 Elmerton Avenue
Harrisburg, PA 17110

Capital

NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Capital Blue Cross and its family of companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Capital Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Capital Blue Cross provides free aids and services to people with disabilities or whose primary language is not English, such as:

- ✓ Qualified sign language interpreters.
- ✓ Written information in other formats (large print, audio, accessible electronic format, other formats).
- ✓ Qualified interpreters, and information written in other languages.

If you need these services, call 800.962.2242 (TTY: 711).

If you believe that Capital Blue Cross 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 our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email at:

Capital Blue Cross
PO Box 779880, Harrisburg, PA 17177-9880
800.417.7842 (TTY: 711), fax: 855.990.9001
CRC@capbluecross.com

If you need help filing a grievance, our Civil Rights 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
Toll-free: 800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

欲免费用本国语言洽询传译员，请拨电话 800.962.2242 (TTY: 711).

Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).

Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).

Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).

무료 전화 통역 서비스 800.962.2242 (TTY: 711).

Per parlare con un interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711).

للتحدث مجانًا إلى مترجم للغتك، يرجى الاتصال بـ 800.962.2242 (الهاتف النصي: 711)

Pour parler à un interpréter dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

ક્ુભાષીયા જોડે વાત કરવા, 800.962.2242 (TTY: 711) પર ફોન કરો.

Aby porozmawiac z tlumaczem w jezyku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711).

Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711).

Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).

Table of Contents

WELCOME

Thank you for choosing *vision coverage* from the Capital Blue Cross family of companies. We are eager for this opportunity to help you and your family on your health and wellness journey.

This *Benefits Booklet* (also known as "Certificate of Coverage") is provided to you as part of the *group contract* entered into between the *contract holder* and us. It explains the *benefits* provided to you under your group health plan. It also defines terms important for your understanding, itemizes what your plan pays for and how, and explains how you can make the most of this coverage. We have also included our contact information so you can reach us when you have questions or concerns.

There are five sections in the *Benefits Booklet* that we would like to call out to help you to better understand your *coverage.* You should take extra time to review the following sections:

1. **How to Access Benefits**, serves as a guide to using and making the most of this *coverage*.
2. **Summary of Benefits**, provides a summary of your *benefits* and any *benefit* limitations under your plan.
3. **Schedule of Limitations/ Schedule of Exclusions**, lists the services limited or not covered under your plan.
4. **Claims Reimbursement,** offers important information on how to file a claim for *benefits*.
5. Appeal Procedures, details the appeal process so you know how to file an appeal, if needed.

Let's Get Started

We want this *Benefits Booklet* to be easy to read and understand. Here are some of our language and format choices to help:

- When we say "you" or "your," we mean you, the subscriber. We may also say "you" or "your" to mean the member, which is anyone covered under your plan **("**dependents**").**
- When we say "we," "us," or "our," we mean Capital Advantage Assurance Company.
- When we use a defined term in a section, we will use *italics* to alert you to look the word up, if you want or need to under ***Definitions***.
- We will use **boldface font** to call out section titles, like ***How to Contact Us***, so you can go to that section to learn more.

Of course, any time you have questions or concerns about your coverage, we encourage you to call Member Services. You will find their number on the back of your *identification (ID) card*.

IMPORTANT NOTICES

There are a few important points that you need to know about your vision *coverage* before you continue reading the remainder of this *Benefits Booklet*:

- This plan may not cover all your vision expenses. You should read this *Benefits Booklet* carefully to determine which vision services are provided as *benefits* under your *coverage*.
- To receive certain *benefits* and pay the least for your vision care, use *in-network providers.*
- We base our *coverage* determinations on whether a vision service is appropriate and is a *benefit* under this *coverage*. We do not reward individuals or providers for denying coverage. And we do not provide them financial incentives to encourage you to use fewer covered services.
- We may contract with other companies to provide certain services, including administrative services, relating to this *coverage*.
- This *Benefits Booklet* replaces any other *Benefits Booklet, Certificates of Coverage,* or Certificates of Insurance we may have issued to you previously under your coverage with the Capital Blue Cross family of companies.
- The *group contract* is nonparticipating in any divisible surplus of premium.
- The *group contract* is available for inspection at the office of the *contract holder* during regular business hours.
- *Capital* does not assume any financial risk or obligation with respect to *benefits* or claims for such *benefits*.
- The *benefits under* this *Benefits Booklet* do not include the e*ssential benefi*ts for pediatric (under the age of *19) visi*on services *under PPACA;* such benefits must be embedded in a Qualified Health Plan, or *QHP*, for medical benefits, as defined in *PPACA.*

HOW TO CONTACT US

We are committed to providing excellent ser*vice to* you. We offer you a variety of ways to connect with us to answer your questions, confirm your benefits and coverage, and more.

Online

Be sure to sign up for a secure account at CapitalBlueCross.com. With it, you can find your *benefits*, claims, and cost-share balances. You can locate *in-network provider*s; change personal information; or request *ID card*s.

Member Services

Member Services representatives can answer your questions, confirm your benefits and coverage, and help you find *in-network providers*. Member Services can also help answer your questions about how to access providers who accommodate your physical disabilities or other special needs. This may include providing interpreting services in your preferred language or translating documents upon request. Language assistance is also available to disabled individuals. Information in Braille, large print or other alternate formats are available upon request at no charge.

Call	1-800-905-4102 or TTY users, 711 during normal business hours
Email	Complete the Contact Us form at CapitalBlueCross.com.
Write	National Vision Administrators P.O. Box 2187 Clifton, NJ 07015
FAX	1-973-574-2430
Walk In	2500 Elmerton Avenue Harrisburg, PA 17177 M-F 8 a.m. to 4:30 p.m.
Visit a Capital Blue Cross Connect health and wellness center	Go to **CapitalBlueCrossConnect.com** or call 855.505.BLUE (2583) to make an appointment or just stop in. M-F 9 a.m. to 6 p.m., Sat. 9 a.m. to 1 p.m. Promenade Shops at Saucon Valley 2845 Center Valley Parkway Suite 404/409 Center Valley, PA 18034 Patrick O'Donnell Pavilion WellSpan Health Campus 12 St. Paul Drive Chambersburg, PA 17201 Hampden Marketplace 4500 Marketplace Way Enola, PA 17025 Capital Blue Cross 1221 Hamilton Street Allentown, PA 18102 Apple Hill Medical Center 25 Monument Rd., Suite 220A York, PA 17402

DEFINITIONS

The terms below have the following meanings whenever italicized in your Benefits Booklet or the *group contract*:

Allowance Amount: The payment level that we reimburse for *benefits* provided to you under your *coverage*.

Annual Enrollment: A specific time period during each calendar year when the *contract holder* permits its employees or *members* to make enrollment changes.

Benefit Period: The specified period of time during which charges for *benefits* must be incurred to be eligible for payment by us. A charge for *benefits* is incurred on the date you received the service or supply or upon completion of the procedure. The *benefit period* does not include any part of a calendar year during which you have no *coverage* under the *group contract*, or any part of a year before the date of this *Benefits Booklet* or a similar provision takes effect.

Benefit Period Program Maximum: The limit of coverage for a *benefit(s)* under the *group contract* within a *benefit period*. Such limits may be in the form of procedures or dollars. *Benefit period* program maximums are described in the **Summary of Benefits** section of this *Benefits Booklet*.

Benefits: Those vision services and supplies covered under, and in accordance with, this *coverage*.

Benefits Booklet (Certificate of Coverage): This document, issued to subscribers as part of the group contract entered into by the contract holder and us. It explains the terms of this coverage, including the benefits available to members and information on how this coverage is administered.

Capital: Capital Blue Cross and Capital Advantage Assurance Company, the entities administering this *coverage*, as indicated on the cover page of this *Benefits Booklet*.

Contract Holder: The organization or firm, usually an employer, union, or association, that contracts with us to provide or administer the coverage offered under your *group* health plan.

Copayment: A fixed amount you pay to the provider for a covered service. Typically, copayments are due at the time of service. Copayments, if any, are identified in the **Summary of Benefits** section or in the applicable rider to this *Benefits Booklet*.

Cosmetic Procedure: An elective procedure performed primarily to restore a person's appearance by surgically altering a physical characteristic that does not prohibit normal function, but is unpleasant or unsightly.

Coverage: The program offered and/or administered by us which provides *benefits* for *members* covered under the *group contract*.

Dependent: Any member of a *subscriber's* family or a *subscriber's domestic partner* who satisfies the applicable eligibility criteria, who enrolled under the *group contract* by submitting an *enrollment application* to us and for whom such *enrollment application* has been accepted by us.

Effective Date of Coverage: The date your *coverage* under the *group contract* begins as shown on our records.

Enrollment Application: The properly completed written or electronic application for membership submitted on a form provided by or approved by us, together with any amendments or modifications.

Group Application: The properly completed written and executed or electronic application for coverage the *contract holder* submits on a form provided by or approved by us, together with any amendments or modifications thereto.

Group Effective Date: The date that is specified in the *group policy/contract* as the original date that the *group contract* became effective.

Group Enrollment Period: A period of time established by the *contract holder* and us from time to time, but no less frequently than once in any 12 consecutive months, during which eligible persons may enroll for *coverage*.

Group Policy/Contract: The legal agreement between the *contract holder* and us for administration and/or coverage of *benefits*.

Identification (ID) Card: The card issued to the *member* that evidences *coverage* under the terms of the *group contract.*

Immediate Family: The *subscriber's* or *member's* spouse, *domestic partner*, parent, step-parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law, child, step-child, grandparent, or grandchild.

In-Network Provider: An *Ophthalmologist, Optometrist,* or *Optician* who is properly licensed, and has a contract with us to provide *benefits* under this *coverage*.

Investigational: For the purposes of the *group contract*, a drug, treatment, device, or procedure is investigational if any of the following:

- It cannot be lawfully marketed without the approval of the Food and Drug Administration ("FDA") and final approval has not been granted at the time of its use or proposed use,
- For a period of up to six (6) months following FDA approval, unless otherwise provided in our applicable medical policies.
- It is the subject of a current Investigational new drug or new device application on file with the FDA;
- The predominant opinion among experts as expressed in medical literature is that usage should be substantially confined to research settings;
- The predominant opinion among experts as expressed in medical literature is that further research is needed in order to define safety, toxicity, effectiveness or effectiveness compared with other approved alternatives;
- It is not investigational in itself, but would not be medically necessary except for its use with a drug, device, treatment, or procedure that is investigational.

In determining whether a drug, treatment, device or procedure is investigational, the following information may be considered:

- Your medical records;
- The protocol(s) pursuant to which the treatment or procedure is to be delivered;

- Any consent document you have signed or will be asked to sign, in order to undergo the treatment or procedure;
- The referred medical or scientific literature regarding the treatment or procedure at issue as applied to the injury or illness at issue;
- Regulations and other official actions and publications issued by the federal government; and
- The opinion of a third party medical expert in the field, obtained by us, with respect to whether a treatment or procedure is investigational.

Level of Coverage: The level of payment made by us to an *in-network provider* or an *out-of-network provider* described in the **Summary of Cost-Sharing and Benefits** section of this *Benefits Booklet*.

Medical Necessity (Medically Necessary): Shall mean:

- Services or supplies that a *physician* exercising prudent clinical judgment would provide to a *member* for the diagnosis and/or direct care and treatment of the *member's* medical condition, disease, illness, or injury that are necessary;
- In accordance with generally accepted standards of good medical practice;
- Clinically appropriate for the *member's* condition, disease, illness or injury;
- Not primarily for the convenience of the *member* and/or the *member's* family, *physician*, or other healthcare *provider*; and
- Not more costly than alternative services or supplies at least as likely to produce equivalent results for the *member's* condition, disease, illness or injury.

For the purpose of this definition, "generally accepted standards of good medical practice" means standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national *physician* specialty society recommendations and the views of *physicians* practicing in relevant clinical areas and any other clinically relevant factors. The fact that a *provider* may prescribe, recommend, order, or approve a service or supply does not make it *medical necessity* or a covered *benefit*.

Member: A *subscriber*, *dependent* or "Qualified Beneficiary" (as defined under *COBRA*) enrolled for *coverage* and entitled to receive covered services under the *group contract* in accordance with its terms and conditions. For the appeal processes, the term includes parents of a minor member as well as designees or legal representatives who are entitled or authorized to act on behalf of the member. The term member is sometimes identified with the pronouns "you" and "your" in this Benefits Booklet.

Ophthalmologist: A person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology.

Optically Necessary/Optical Necessity: A prescription or a change of prescription is required to correct visual function.

Optician: A person or business licensed by the state in which services are rendered to manufacture, grind and/or dispense lenses and frames prescribed by either an *Optometrist* or an *Ophthalmologist*.

Optometrist: A person licensed to practice Optometry as defined by the laws of the state in which his or her services are rendered.

Out-of-network Provider: A provider who is not under contract with us or a *provider* who is not an *in-network provider.*

PPACA: The Patient Protection and Affordable Care Act of 2010 and its related regulation, each as amended.

Provider: A person or practitioner licensed (where required) and performing services within the scope of such licensure and as identified in this *Benefits Booklet*. Providers include *in-network providers* and *out-of-network providers*.

Retiree: A former employee of the *contract holder* who meets the *contract holder's* definition of a retired employee and to whom the *contract holder* offers *coverage* under the *group contract*, if any. The *contract holder* must designate and we must agree that one or more classes of retired former employees of the *contract holder* are eligible to receive *coverage* for *benefits* under the *group contract* in order for a person to qualify as a retiree.

Service Area: The following 21 Pennsylvania counties in which we offer *coverage*: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York.

Services: Treatment performed by an *Ophthalmologist, Optometrist,* or *Optician* or under his/her supervision and direction and when necessary, customary and reasonable, as determined by us, using standards of generally accepted vision practice.

Standard Lenses: Any size lenses manufactured from glass or plastic, which are optically clear; standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, glass trifocals through flat top 28 and plastic trifocals through flat top 35.

Subscriber: A person whose employment or other status, except for family dependency, is the basis for eligibility for enrollment for *coverage* under the *group contract*, who enrolled under the *group contract* by submitting an *enrollment application* to us and for whom such *enrollment application* has been accepted by us. Subscriber may include, without limitation, a *retiree*. A subscriber is also a *member*.

Treatment: Caring for or dealing with a vision condition.

Vision Examination: An examination of principal vision functions. A *vision examination* includes, but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The exam will be consistent with the community standards, rules and regulations of the jurisdiction in which the *provider* practice is located.

HOW TO ACCESS BENEFITS

ID Card

Your *ID card* is the key to accessing the *benefits* provided under this *coverage* with us.

You should show your *ID card* and any other ID cards for other vision coverage **each time you seek vision services**. *Providers* use the information from your *ID card* to submit *claims* for processing and payment.

Important Information about Your *ID card*:

- The words "Capital Blue Cross *Vision*" on the front of the card inform *providers* that you have vision coverage with us.
- On the back of the *ID card*, you will find the Capital Blue Cross *Vision* telephone number.

Please call Member Services if any information on your ID card is incorrect or if you have questions. Remember to destroy old ID cards and use only the most recent ID card.

Obtaining Benefits for Vision Services

We classify providers as either "in network" or "out of network." (You may have also heard the term "participating" or "nonparticipating." These terms mean the same thing.) The provider you select is — without limitation — in charge of your care, but your costs will generally be less if you choose an in-network provider.

Stay current about your providers. To confirm your providers are in network, go to CapitalBlueCross.com or call Member Services. You will find their number on the back of your ID card.

Depending on your specific *coverage*, the *benefits* provided and the level of payment for *benefits* is affected by whether you choose an in-network *provider.*

You can choose any licensed *Ophthalmologist*, *Optometrist*, or *Optician* for their care, although their costs are generally less when they see an in-network *provider*. You have the option to visit an *out-of-network provider*, but it generally costs you more. *Providers*, including, without limitation, *in-network providers*, are solely responsible for the vision care rendered to their patients.

NOTE: Remember, you have the greatest savings when you choose an in-network *provider*.

Services Provided By In-Network Providers

You can maximize your *coverage* and minimize your out-of-pocket expenses by visiting an *in-network provider*.

***In-network providers* may seek payment for the member portion of the costs for services and/or supplies that qualify as *benefits*.** An in-network *provider* may seek payment from you for noncovered services, including specifically excluded services (e.g., *cosmetic procedures*, investigational procedures, etc.), or services in excess of *benefit period maximums*. The *in-network provider* must inform you prior to performing the noncovered services that you may be liable to pay for these services, and you must agree to accept this liability.

The status of an *Ophthalmologist*, *Optometrist*, or *Optician* as an in-network *provider* may change from time to time. It is your responsibility to verify the current status of a *provider*. To find an in-network provider*, members* can visit capbluecross.com or call 1-800-905-4102.

Services Provided By Out-of-Network Providers

Services provided by *out-of-network providers* may require higher *member* portion of costs or may not be covered *benefits*. If such services are covered, *benefits* will be reimbursed at the *allowance amount* applicable to this *coverage*. Information on whether *benefits* are provided when performed by an out-of-network *provider* and the applicable level of payment for such *benefits* is noted in the **Summary of Benefits**.

Out-of-Country Services

When you travel outside the United States and need vision care, you should go to the nearest appropriate treatment facility. When you receive out-of-country services, you must pay for treatment at the time of service and get a detailed receipt from the treating provider. In addition to providing the *provider's* name and address (including country), the receipt should describe the *vision* services performed by the *provider*. It should also indicate whether the provider's charges were billed in U.S. dollars or another currency.

Reimbursement is subject to the terms and conditions of *your* vision coverage, and is based on the out-of-network *benefit* provided through the *group contract*.

SUMMARY OF BENEFITS

The following table provides a summary of the *benefits* provided under this *coverage*.

The *benefits* listed in this section are covered when provided by a properly licensed *Ophthalmologist*, *Optician* or *Optometrist* within the standards of generally accepted vision practice.

It is important to remember that this *coverage* is subject to the exclusions and limitations as described in this *Benefits Booklet*. Please see the **Schedule of Limitations,** and **Schedule of Exclusions** sections for specific *benefit* limitations and/or exclusions provided under this *coverage*.

SUMMARY OF BENEFITS		
Benefit frequencies are based on the date of service.	**Amounts You Are Responsible For:**	
	In-Network Providers	***Out-of-Network Providers***
EXAMINATION		
Benefit frequency once every twelve months	Covered in full	Balance of retail charge after $40 allowance
CONTACT LENS FITTING & FOLLOW-UP		
Benefit frequency once every twelve months		
• Daily Wear Contacts	Covered in full	Balance of retail charge after $20 allowance
• Extended Wear Contacts	Covered in full	Balance of retail charge after $30 allowance
• Specialty Contacts	$30 copayment	Not Covered
FRAMES		
Benefit frequency once every twenty-four months**	Balance of wholesale charge after $50 allowance*	Balance of retail charge after $40 allowance
EYEGLASS LENSES (PER PAIR)		
Benefit frequency once every twelve months		
• Single Vision *Standard Lenses*	Covered in full	Balance of retail charge after $40 allowance
• Bifocal *Standard Lenses*	Covered in full	Balance of retail charge after $55 allowance
• Trifocal *Standard Lenses*	Covered in full	Balance of retail charge after $90 allowance
• Aphakic/Lenticular *Standard Lenses*	Covered in full	Balance of retail charge after $120 allowance
• Polycarbonate *Standard Lenses* (under age 19)	Covered in full	Not Covered
CONTACT LENSES		
Benefit frequency once every twelve months		
• Disposable Lenses (unlimited boxes)	Balance of retail charge less 25% after $120 allowance**	Balance of retail charge after $110 allowance

SUMMARY OF BENEFITS		
Benefit frequencies are based on the date of service.	**Amounts You Are Responsible For:**	
	In-Network Providers	***Out-of-Network Providers***
• Conventional Lenses including but not limited to: Hard/soft daily wear and spherical.	Balance of retail charge less 25% after $120 allowance**	Balance of retail charge after $110 allowance
• Specialty Lenses including but not limited to: Bifocal, toric or gas permeable.	Balance of retail charge less 25% after $120 allowance**	Balance of retail charge after $110 allowance
• Lenses (per pair) that are *medically necessary* and appropriate	Covered in Full	Covered in Full

*Discounted amounts may vary and may not be honored at all *in-network provider* locations.

**Frame allowance at Walmart® Vision Centers & Sam's Club is 50% of the frame allowance shown above with no additional retail discount.

***Contact lens allowance at Walmart® Vision Centers & Sam's Club is 75% of the contact lens allowance shown above with no additional retail discount.

VALUE ADDED DISCOUNTS – LENS OPTIONS:

In addition to the standard *benefits* program, Value Added Vision discounts may be available when services are rendered by in-network providers. The discounted pricing is not considered insured benefits under this contract. It is a reduced fee-for-service program. You pay a reduced fee for specific services provided by contracted *providers*. We do not pay contracted *providers* for these services. Discounted pricing does not apply at Walmart or Sam's Club. Discounted amounts may vary and may not be honored at all *in-network provider* locations.

Lens Options purchased from an *in-network provider* will be provided to you at the amounts listed below. Lens Options not listed may be discounted 20% of the retail charge. Lens Options that are purchased from an out-of-network *provider* will not be discounted and are your full responsibility.

Contact your group leader for a list of discounted services.

VALUE ADDED PLUS

After you have exhausted your funded *benefits* you are eligible to access discounts on additional purchases during the *benefit period* through the Value Added Plus option. Discounts through the Value Added Plus option may be available when services are rendered by in-network providers. The discounted pricing is not considered insured *benefits* under this coverage. It is a reduced fee-for-service program. You pay a reduced fee for specific services provided by contracted *providers*. We do not pay contracted *providers* for these services. Discounted pricing does not apply at Walmart, Sam's Club and Contact Fill. Discounted amounts may vary and may not be honored at all *in-network provider* locations.

Contact your group leader for a list of discounted services.

SCHEDULE OF LIMITATIONS

In addition to the exclusions listed in the *Schedule of Exclusions* section, the *benefits* provided under your vision *coverage* have the following limitations:

1. Payment will be made for either eyeglass lenses or contact lenses within a *benefit period*. Payment will not be made for both.

2. *In-network providers* are not contractually obligated to offer sale prices in addition to the out lined *coverage*.

3. Regardless of *optical necessity*, vision *benefits* are not available more frequently than specified in the **Summary of Benefits** section.

SCHEDULE OF EXCLUSIONS

Except as specifically provided in this *Benefits Booklet*, we will not provide *benefits* under your vision *coverage for* the following services, supplies, or charges:

1. Services or supplies which are provided by any federal or state government agency except Medicaid, or by any municipality, county, or other political subdivision;
2. Services that are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury;
3. Charges for which benefits or services are provided to you by any hospital, medical or vision service corporation, any group insurance, franchise, or other prepayment plan for which an employer, union, trust or association makes contributions or payroll deductions (unless the coordination of benefit provisions provide otherwise);
4. Services provided or supplies furnished or devices started prior to your effective date of *coverage*;
5. Treatment or supplies which you would have no legal obligation to pay;
6. Professional services and/or materials in connection with blended bifocals, no line, or progressive addition lenses; compensated or special multi-focal lenses; plain (nonprescription) lenses; anti-reflective, scratch, UV400, or any coating of lamination applied to lenses; and tints other than solid;
7. Examinations or materials which are not listed herein as a covered service;
8. Medical attention or surgical treatment of the eye, eyes or supporting structures;
9. Drugs or any other medications;
10. Procedures determined to be special or unusual (orthoptics, vision training, tonography, etc.);
11. *Vision examinations* or materials required for employment;
12. V*ision examinations* or materials sponsored by the *subscriber's* employer without charge to the *subscriber*;
13. Duplicate and temporary devices, appliances, and services;
14. Replacement of lost, stolen, broken or damaged lenses, contact lenses or frames, unless the member would otherwise meet the frequency limitations;
15. Parts or repair of frames;
16. Lenses which do not require a prescription;
17. Sunglasses;
18. Two pair of glasses in lieu of bifocals;
19. Low vision aids (i.e., magnifying glasses to help people with severe sight issues);
20. Industrial safety lenses and safety frames with or without side shields;
21. Services incurred after your termination date of coverage except as provided for in this *Benefits Booklet*;

22. Services received in a country with which United States law prohibits transactions;
23. Charges that exceed the *allowance amount;*
24. Cost-sharing amounts you must pay as outlined in this Benefits Booklet;
25. Travel expenses incurred together with *benefits*;
26. Court ordered services when not of *optical necessity* and/or not a covered *benefit*;
27. Any services rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required under law;
28. Services not billed by an eligible *provider;*
29. Vision services rendered by a *provider* who is a member of your *immediate family*;
30. Telephone and electronic consultations, including virtual services, between you and a *provider*;
31. Charges for failure to keep a scheduled appointment with a *provider*, for completion of a claim or insurance form, for obtaining copies of vision records, or your decision to cancel a vision procedure;
32. Any other service or treatment, except as provided in this *Benefits Booklet*.

MEMBERSHIP STATUS

To be considered a *subscriber*, child or *dependent* under this *coverage*, an individual must meet certain eligibility requirements and enroll (apply) for coverage within a specific timeframe.

There is a limited period of time to submit an *enrollment application* for initial enrollment and enrollment changes. *Subscribers* should consult with the *contract holder* to determine the specific timeframes applicable to them. *Subscribers* who fail to submit an *enrollment application* within these specific timeframes may not be allowed to enroll themselves and/or their newly eligible *dependents* until the next *annual enrollment* period. *Subscribers* should refer to the Timelines for Submission of Enrollment Applications section of this *Benefits Booklet* for more details.

Eligibility

Individuals must meet specific eligibility requirements to enroll or to continue being enrolled for coverage, unless otherwise approved in writing by us in advance of the *effective date of coverage*.

Nondiscrimination

We will not discriminate against any *subscriber* or *member* in eligibility, continued eligibility or variation in premium amounts by virtue of any of the following: (i) the *subscriber* or *member* taking any action to enforce his/her rights under applicable law; (ii) on the basis of race, color, national origin, disability, sex, gender identity or sexual orientation; or (iii) health status-related factors pertaining to the *subscriber* or *member*. Factors include health status, medical condition, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability and disability.

Subscriber

An individual must meet all eligibility criteria specified by the *contract holder* and approved by us to enroll in this *coverage* as a *subscriber*. These criteria include meeting all requirements to participate in the *contract holder's* health benefit program, including compliance with any probationary or waiting period established by the *contract holder*.

Dependent - Spouse

An individual must be the lawful spouse of the *subscriber* to enroll in this *coverage* as a *dependent* spouse.

We reserve the right to require that a spouse of a *subscriber* provide documentation demonstrating marriage to the *subscriber*, including, but not limited to, marriage certificate, court order or joint statement of common law marriage as determined by us.

Dependent – Domestic Partner

To enroll in this *coverage* as a *dependent* domestic partner, an individual must be in a relationship with another adult partner of the same or opposite sex, and who live together and share a domestic life, but are not married or joined by a civil union.

We reserve the right to request documentation that demonstrates domestic partnership prior to commencing *coverage* for the domestic partner.

Child

To enroll under this *coverage* as a child, an individual must be under the age of 26 and meet one of the following criteria:

- A birth child of the *subscriber* or the *subscriber's* spouse, or the *subscriber's domestic partner*;
- A child legally adopted by or placed for adoption with the *subscriber* or the *subscriber's* spouse, , or the *subscriber's domestic partner*;
- A ward*,* (a child for whom the *subscriber* or the *subscriber's* spouse, or the *subscriber's domestic partner* has been granted legal custody by a court of competent jurisdiction);
- A child for whom the *subscriber* or the *subscriber's* spouse, or the *subscriber's domestic partner* is required to provide healthcare coverage pursuant to a *Qualified Medical Child Support Order* (QMCSO).

Dependent ‑Child Age 26 or Older with a Disability

An individual must be an unmarried child age 26 or older to enroll under this *coverage* as a *dependent* child with a disability. The child must meet all of the following criteria:

- A birth child, adopted child, or *ward* of the *subscriber* or the *subscriber's* spouse, or the *subscriber's domestic partner*.
- Mentally or physically incapable of earning a living; or unable to engage in self-sustaining employment by reason of any medically determinable physical or mental impairment(s) which has lasted or can be expected to last for a continuous period of not less than 12 months.
- Chiefly dependent upon the *subscriber,* or the *subscriber's* spouse, or the *subscriber's domestic partner* for support and maintenance, provided that all the following are true:
  - The incapacity began before age 26.
  - The *subscriber* provides us with proof of incapacity within 31 days after the *dependent* child with a disability reaches age 26.
  - The *subscriber* provides related information as otherwise requested by us, but not more frequently than annually.

Extension of Eligibility for Students on Military Duty

Eligibility to enroll under this *coverage* as a child will be extended, regardless of age, when the child's education program at an accredited educational institution was interrupted due to military duty. In order to be eligible for the extension of eligibility, the child must have been a full time student eligible for health insurance coverage under their parent's health insurance policy and either of the following:

- A member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States who was called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days; or
- A member of the Pennsylvania National Guard ordered to active State duty, including duty under 35 Pa.C.S. Ch. 76 (relating to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

The extension of eligibility will apply so long as the child maintains enrollment as a full time student, and shall be equal to the duration of service on active duty or active State duty.

To qualify for this extension of eligibility the child must submit the following forms to us:

- The form approved by the Pennsylvania Department of Military and Veterans Affairs which notifies an insurer that the *dependent* has been placed on active duty;
- The form approved by the Pennsylvania Department of Military and Veterans Affairs which notifies an insurer that the *dependent* is no longer on active duty;
- The form approved by the Pennsylvania Department of Military and Veterans Affairs which shows that the *dependent* has reenrolled as a full-time student for the first term or semester starting 60 or more days after the *dependent's* release from active duty.

The above forms can be obtained by contacting the Pennsylvania Department of Military and Veterans Affairs or visiting their website.

Enrollment

When *members* "enroll" with us, they agree to participate in a contract for *benefits* between the *contract holder* and us. All qualified requests to enroll or to change enrollment must be made through the *contract holder*.

Every *member* must complete and submit to *Capital*, through the *contract holder*, an application for *coverage*, which is available from the *contract holder*. Each *member* must also enroll within certain time periods after becoming eligible. These requirements are described in the *group policy*.

Timelines for Submission of Enrollment Applications

There is a limited period of time to submit an *enrollment application* for initial enrollment and enrollment changes. *Subscribers* should consult with the *contract holder* to determine the specific timeframes applicable to their *coverage*. However, we will only accept from the *contract holder enrollment applications* for initial enrollment or enrollment changes up to 60 days after the *member* is eligible for *coverage* under the *group contract*. Therefore, the *subscriber* should immediately submit an *enrollment application* to the *contract holder* to allow the *contract holder* ample time to submit the *enrollment application* to us.

Subscribers who fail to submit an *enrollment application* within these specific timeframes may not be allowed to enroll themselves and/or their newly eligible *dependents* until the next *annual enrollment* period.

Initial Enrollment

"Initial" is the term used to represent eligible *members* enrolling for *coverage* with us for the first time. The initial *group enrollment period* is during the time-period designated by the *contract holder*. *Members* should refer to the sections below for more information on eligibility outside of the initial *group enrollment period*.

Newly Eligible Members

Eligible *subscribers* and *dependents* may enroll for *coverage* when they first meet the appropriate requirements described in the **Eligibility** section. This may occur during the initial *group enrollment*

period or at some other time, based on the eligibility rules established by the *contract holder* and us or as provided by law.

Subscriber

A new *subscriber* may enroll with us for *coverage* after becoming eligible, even though a *group enrollment period* is not in progress. *Subscribers* must immediately submit an *enrollment application* through the *contract holder* to ensure that they enroll within the required timeframes. Newly eligible *subscribers* should consult with the *contract holder* to determine the timeframes applicable to their *coverage*. *Members* should refer to the **Timelines for Submission of Enrollment Applications** section for more details.

Life Status Change

An individual who does not enroll when first eligible must wait until the next *group enrollment period*. However, individuals who experience a life status change may enroll in *coverage* as a new *subscriber* or *dependent* even though a *group enrollment period* is not in progress. A life status change is an event based on, but not limited to the following:

- A change in job status;
- A change in marital status;
- A change in *domestic partnership*;;
- The birth adoption, or placement for adoption of a child;
- Acquiring a stepchild or becoming a legal guardian for a child;
- A court order;
- A change in *Medicare* status;
- A change in the status of other insurance;
- Loss of other minimum essential coverage, including but not limited to, a loss due to termination of employment or reduction in hours, divorce or legal separation, relocation outside our *service area*, or a child ceasing to be eligible for *coverage* under the *group contract*;

If one of these events occurs, you must notify the *contract holder* immediately. To enroll with us for *coverage*, *members* must enroll within the required timeframe after one of the following, as applicable:

- The date of marriage, birth, adoption or placement for adoption, or in the case of a *ward*, the date specified in the legal custody order; or
- The date of the loss of the other health insurance coverage.

The *subscriber* must submit an *enrollment application* through the *contract holder* within the required timeframes after the newly eligible *dependent* becomes eligible for *coverage* under the *group contract*. *Subscribers* should consult with the *contract holder* to determine the timeframes applicable to enrolling newly eligible *dependents*. Refer to the **Timelines for Submission of Enrollment Applications** section for more details.

Group Enrollment Period

During a *group enrollment period*, you have the opportunity to make healthcare coverage changes, if applicable, and to add eligible *dependents* previously not enrolled. A *group enrollment period* occurs at least once annually.

Effective Date of Coverage

Initial and Newly Eligible Members

Coverage for initial and newly eligible *members* are effective as of the date specified by the *contract holder and approved by* us*. Members* should contact the *contract holder* for details regarding specific *effective dates of coverage*. These requirements are also described in the *group policy*.

Life Status

Individuals who enroll within the required timeframes are covered as of the following dates, as applicable:

- The date of birth, adoption or placement for adoption;
- The date specified in the legal custody order, in the case of a ward;
- The date of marriage;
- The date of attaining eligibility as a d*omestic partner*;
- First date after loss of other health insurance coverage;
- First day of the month following enrollment after an individual loses other minimum essential coverage.

Except as set forth above, *coverage* will begin the first day of the first calendar month beginning after the date we receive the request for enrollment following a life status change.

TERMINATION OF COVERAGE

This section explains when and why your *coverage* with us may end.

Termination of Group Contract

When the group contract ends, it automatically terminates *coverage* for all *members* in that group. The terms and conditions related to the termination and renewal of the *group contract* are described in the *group contract*, a copy of which is available for inspection at the office of the *contract holder* during regular business hours.

Termination of Coverage for Members

You cannot be terminated based on health status, healthcare need, or the use of *Capital's adverse benefit determination* appeal procedures.

However, there are situations where a *member's coverage* is terminated even though the *group contract* is still in effect. These situations include, but are not limited to the following:

- *Subscriber* - *Coverage* ends on the date in which a *subscriber* is no longer employed by, or a member of, the company or organization sponsoring this *coverage*. When *coverage* of a *subscriber* is terminated, *coverage* for all of the *subscriber's dependents* is also terminated.
- *Dependent* Spouse - *Coverage* of a *dependent* spouse ends on the date in which the *dependent* spouse ceases to be eligible under this *coverage*.
- *Dependent Domestic Partner* - *Coverage* of a *dependent domestic partner* ends on the date in which the *dependent domestic partner* ceases to be eligible under this *coverage.*
- Child - *Coverage* of a child ends on the date in which the child is no longer eligible as described in the **Enrollment** section. However, *coverage* of a child may continue as a *dependent* disabled child as described in the **Membership Status** section.
- *Dependent* Disabled Child - *Coverage* of a *dependent* disabled child ends when the *subscriber* does not submit to us, through the *contract holder*, the appropriate information as described in the **Membership Status** section. The *subscriber* must notify us of a change in status regarding a *dependent* disabled child.

In addition, *coverage* terminates for *members* if they participate in fraudulent behavior or intentionally misrepresent material facts, including but not limited to the following:

- Using an *ID card* to obtain goods or services:
  - ◊ Not prescribed or ordered for the *subscriber* or the *subscriber's dependents* or
  - ◊ To which the *subscriber* or the *subscriber's dependents* are otherwise not legally entitled.
- Allowing any other person to use an *ID card* to obtain services. If a *dependent* allows any other person to use an *ID card* to obtain services, *coverage* of the *dependent* who allowed the misuse of the *ID card* is terminated.

- Knowingly misrepresenting or giving false information, or making false statements that materially affect either the acceptance of risk or the hazard assumed by us, on any *enrollment application* form.

The actual termination date is the date specified by the *contract holder* and approved by us. *Members* should check with the *contract holder* for details regarding specific termination dates. Except as provided for in this *Benefits Booklet*, if a *member's benefits* under this *coverage* are terminated under this section, all rights to receive *benefits* cease at 11:59:59 PM, local Harrisburg, Pennsylvania time, on the date of termination, including maternity *benefits*.

CONTINUATION OF COVERAGE AFTER TERMINATION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) Coverage

COBRA is a federal law, which requires that, under certain circumstances, the *contract holder* give the *subscriber* and the *subscriber's dependents* the option to continue under this *coverage* with us.

Members should contact the *contract holder* if they have any questions about eligibility for *COBRA* coverage. The *contract holder* is responsible for the administration of *COBRA* coverage.

CLAIMS REIMBURSEMENT

Claims and How They Work

To receive payment for *benefits* under this *coverage,* a claim for *benefits* must be submitted to us. The claim is based upon the itemized statement of charges for vision services and/or supplies provided by a *provider*. After receiving the claim, we will process the request and determine if the services and/or supplies provided under this *coverage* are *benefits* provided by your *coverage*, and if applicable, make payment on the claim. The method by which we receive a claim for *benefits* is dependent upon the type of *provider* from which the you receive services. *Providers* that are excluded or debarred from governmental plans are not eligible for payment by us.

In-Network providers

When you receive services and/or supplies from an *in-network provider*, show your *ID card* to the *provider*. The *in-network provider* will submit a claim for *benefits* directly to us. You will not need to submit a claim. Payment for *benefits* is made directly to the *in-network provider*.

Out-of-Network providers

If you visit an out-of-network *provider*, you may be required to pay for the service and/or supplies at the time it is rendered. Although some *out-of-network providers* file claims on behalf of our *members*, they are not required to do so. Therefore, you need to be prepared to submit your claim to us for reimbursement. Payment for services provided by *out-of-network providers* is made directly to the *subscriber*. It is then the *subscriber's* responsibility to pay the *out-of-network provider*, if payment has not already been made.

Allowance Amount

The *benefit* payment amount is based on the *allowance amount* on the date the service is rendered or on the date the expense is deemed incurred by us.

Filing A Claim

We do not require any special vision claim form. *In-network providers* will fill out and submit the claims. Some *out-of-network providers* may also provide this service upon request. If you receive services from an *out-of-network provider* who does not provide this service, you can submit your own claim directly to us at the mailing address listed below. A separate claim form must be completed for each *member* who received vision services. For your convenience, you can print a claim form from our website at CapitalBlueCross.com.

National Vision Administrators
P.O. Box 2187
Clifton, NJ 07015

You must also provide additional information, if applicable, including but not limited to, other insurance payment information. If you need help submitting a vision claim, you can contact Member Services at **1-800-905-4102**.

We will contact you and/or the *provider* if additional information is needed.

Out-of-Country Claims

When you obtains vision services outside of the United States, you must pay for the treatment at the time of service, get a detailed receipt from the treating provider, and then submit the claim to us.

In addition to providing the provider's name and address (including country), the receipt should describe the *vision* services performed by the provider. It should also indicate whether the provider's charges were billed in U.S. dollars or another currency.

Reimbursement is subject to the terms and conditions of this vision coverage, and is based on the out-of-network benefit provided through the group contract.

Claim Filing and Processing Time Frames

Time Frames for Submitting Vision Claims

All claims must be submitted within 12 months from the date of service.

Time Frames Applicable to Vision Claims

If your claim involves a vision service or supply that was already received, we will process the claim within 30 days of receiving the claim. We may extend the 30-day time period one time for up to 15 days for circumstances beyond our control. We will notify you prior to the expiration of the original time period if we need an extension. We may also mutually agree to an extension if either of us requires additional time to obtain information needed to process the claim.

Coordination of Benefits (COB)

The coordination of *benefits* provision applies when a person has healthcare coverage under more than one Plan as defined below.

The order of benefit determination rules govern the order in which each Plan pays a claim for benefits.

- The Plan that pays first is the "Primary Plan." The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- The Plan that pays after the Primary Plan is the "Secondary Plan." The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions Unique to Coordination of Benefits

In addition to the defined terms in the **Definitions** section, the following definitions apply to this provision:

Plan: Plan means This Coverage and/or Other Plan.

Other Plan: Other Plan means any individual coverage or group arrangement providing healthcare benefits or services through any of the following:

1. Individual, group, blanket or franchise insurance coverage except that it shall not mean any blanket student accident coverage or hospital indemnity plan of $100 or less;

2. Blue Cross, Blue Shield, group practice, individual practice, and other prepayment coverage;

3. Coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and

4. Coverage under any tax-supported or any government program to the extent permitted by law.

Other Plan shall be applied separately with respect to each arrangement for benefits or services and separately with respect to that portion of any arrangement, which reserves the right to take benefits or services of Other Plans into consideration in determining its benefits and that portion which does not.

This Coverage: This Coverage means, in a COB provision, the part of the contract providing the healthcare benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing healthcare benefits is separate from This Coverage. A contract may apply one COB provision to certain benefits, such as vision benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rule: The order of benefit determination rules determine whether This Coverage is a Primary Plan or Secondary Plan when you have healthcare coverage under more than one Plan.

Primary Plan: The Plan that typically determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits.

Secondary Plan: The Plan that typically determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100 percent of the total Allowable Expense deemed customary and reasonable by *Capital*.

Covered Service: A service or supply specified in This Coverage for which *benefits* will be provided when rendered by a *provider* to the extent that such item is not covered completely under the Other Plan.

When *benefits* are provided in the form of services, the reasonable cash value of each service shall be deemed the *benefit*.

NOTE: When *benefits* are reduced under the primary contract because you do not comply with the provisions of the Other Plan, the amount of such reduction will not be considered an Allowable Expense under This Coverage.

We will not be required to determine the existence of any Other Plan, or amount of benefits payable under any Other Plan, except This Coverage.

The payment of *benefits* under This Coverage shall be affected by the benefits that would be payable under Other Plans only to the extent that we are furnished with information regarding Other Plans by the *contract holder* or *subscriber* or any other organization or person.

Allowable Expense: Allowable expense is a healthcare expense, including *deductibles*, *coinsurance*, and *copayments*, that is covered at least in part by any Plan covering the *member*. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable Expense. In addition, any expense that a *provider* by law or in accordance with a contractual agreement is prohibited from charging a *member* is not an Allowable Expense.

Examples of expenses that are not Allowable Expenses include, but are not limited to the following:

- Any amount in excess of the highest reimbursement amount for a specific benefit when two or more Plans that calculate benefit payments based on usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology cover the *member*.

- Any amount in excess of the highest of the negotiated fees when two or more Plans that provide benefits or services based on negotiated fees cover the *member*.

- If the *member* is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology covers a person and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the *provider* has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the *provider's* contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

- The amount of any benefit reduction by the Primary Plan because the *member* has failed to comply with the Plan provisions.

Closed Panel: Closed panel plan is a Plan that provides healthcare benefits to covered persons primarily in the form of services through a panel of *providers* that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other *providers*, except in cases of emergency or referral by a panel member. An HMO is an example of a closed panel plan.

Custodial Parent: Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

Dependent: A dependent means, for any Other Plan, any person who qualifies as a dependent under that plan.

Order of Benefit Determination Rules

When a *member* is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

2. A Plan that does not have a coordination of benefits provision as described in this section is always the Primary Plan unless both Plans state that the Plan with a coordination of benefits provision is primary.

3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

4. Each Plan determines its order of *benefits* using the first of the following rules that apply:

   a. Nondependent or Dependent.

      (i) The Plan that covers the *member* as an employee, policyholder, subscriber or retiree is the Primary Plan. The Plan that covers the *member* as a Dependent is the Secondary Plan.

   b. Child Covered Under More Than One Plan.

      (i) Unless there is a court decree stating otherwise, when a child is covered by more than one Plan, the order of benefits is determined as follows:

      (ii) For a child whose parents are married or are living together, whether or not they have ever been married:

      - The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan. This is known as the Birthday Rule; or
      - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan; or
      - If one of the Plans does not follow the Birthday Rule, then the Plan of the child's father is the Primary Plan. This is known as the Gender Rule.

      (iii) For a child whose parents are divorced, separated or not living together, whether or not they have ever been married:

      - If a court decree states that one of the parents is responsible for the child's healthcare expenses or coverage and the Plan of that parent has actual knowledge of this decree, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
      - If a court decree states that both parents are responsible for the child's healthcare expenses or coverage, the provisions of subparagraph (i) determine the order of benefits;
      - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or coverage of the child, the provisions of subparagraph (i) determine the order of benefits; or
      - If there is no court decree allocating responsibility for the child's healthcare expenses or coverage, the order of benefits for the child is as follows:
        - ◊ The Plan covering the Custodial Parent;
        - ◊ The Plan covering the spouse of the Custodial Parent;
        - ◊ The Plan covering the noncustodial parent; and then
        - ◊ The Plan covering the spouse of the noncustodial parent.

      (iv) For a child covered under more than one Plan of individuals who are <u>not</u> the parents of the child, the provisions of Subparagraph (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.

c. Active Employee or Retired or Laid-off Employee.

The Plan that covers the *member* as an active employee is the Primary Plan. The Plan covering that same *member* as a retired or laid-off employee is the Secondary Plan. The same would hold true if the *member* is a Dependent of an employee covered by the active, retired or laid-off employee.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Nondependent or Dependent "rule can determine the order of benefits.

d. *COBRA* or State Continuation Coverage.

If a *member* whose coverage is provided pursuant to *COBRA* or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the *member* as an employee, subscriber or retiree or covering the *member* as a Dependent of an employee, subscriber or retiree is the Primary Plan. The *COBRA* or state or other federal continuation coverage is the Secondary Plan.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Nondependent or Dependent" rule can determine the order of benefits.

e. Longer or Shorter Length of Coverage.

The Plan that covered the *member* as an employee, policyholder, subscriber or retiree longer (as measured by the effective date of coverage) is the Primary Plan and the Plan that covered the *member* the shorter period of time is the Secondary Plan. The status of the *member* must be the same for all Plans for this provision to apply. The same primacy would be true if the *member* is a dependent of an employee covered by the Longer or Shorter length of coverage.

If the preceding rules do not determine the order of benefits, the Allowable Expense is shared equally between the Plans. In addition, This Coverage will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Coverage

When This Coverage is secondary, it may reduce benefits so that the total paid or provided by all Plans for a service are not more than the total Allowable Expenses.

In determining the amount to be paid, the Secondary Plan calculates the benefits it would have paid in the absence of other coverage. That amount is compared to any Allowable Expense unpaid by the Primary Plan. The Secondary Plan may then reduce its payment so that the unpaid Allowable Expense is the considered balance. When combined with the amount paid by the Primary Plan, the total benefits paid by all Plans may not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan credits to its *deductible* any amounts it would have otherwise credited to the *deductible*.

If a *member* is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel *provider*, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under This Coverage and other Plans. We may obtain and use the facts it needs to apply these rules and determine benefits payable under This Coverage and other Plans covering the *member* claiming benefits. We need not tell, or get the consent of, the *member* or any other person to coordinate benefits. Each *member* claiming benefits under This Coverage must give us any facts needed to apply those rules and determine *benefits* payable.

Failure to complete any forms required by us may result in claims being denied.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Coverage. If it does, we may pay that amount to the organization that made the payment. That amount is treated as though it is a benefit paid under This Coverage. We will not pay that amount again. The term "payment made" includes providing *benefits* in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by us is more than the amount that should have been paid under this COB provision, we may recover the excess amount. The excess amount may be recovered from one or more of the persons or organization paid or for whom it has paid, or any other person or organization that may be responsible for the *benefits* or services provided for the *member*. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Third Party Liability/Subrogation

Subrogation is the right of the *contract holder* to recover the amount it has paid on behalf of a *member* from the party responsible for the *member's* injury or illness.

To the extent permitted by law, a *member* who receives *benefits* related to injuries caused by an act or omission of a third party or who receives benefits and/or compensation from a third party for any care or treatment(s) regardless of any act or omission, shall be required to reimburse the *contract holder* for the cost of such *benefits* when the *member* receives any amount recovered by suit, settlement, or otherwise for his/her injury, care or treatment(s) from any person or organization. The *member* shall not be required to pay the *contract holder* more than any amount recovered from the third party.

In lieu of payment above, and to the extent permitted by law, the *contract holder* may choose to be subrogated to the *member's* rights to receive compensation including, but not limited to, the right to bring suit in the *member's* name. Such subrogation shall be limited to the extent of the *benefits* received under the *group contract*. The *member* shall cooperate with the *contract holder* should the *contract holder* exercise its right of subrogation. The *member* shall cooperate with *Capital* if the *contract holder* chooses to have *Capital* pursue the right of subrogation on behalf of the *contract holder*. The *member* shall not take any action or refuse to take any action that would prejudice the rights of the *contract holder* under this **Third Party Liability/Subrogation** section.

The right of subrogation is not enforceable if prohibited by applicable controlling statute or regulation.

There are three basic categories of medical claims that are included in *the contract holder's* subrogation process: third party liability, workers' compensation insurance, and automobile insurance.

Third Party Liability

Third party liability can arise when a third party causes an injury or illness to a *member*. A third party includes, but is not limited to, another person, an organization, or the other party's insurance carrier.

When a *member* receives any amount recovered by suit, settlement or otherwise from a third party for the injury or illness, subrogation entitles the *contract holder* to recover the amounts already paid by the *contract holder* for claims related to the injury or illness. The *contract holder* does not require reimbursement from the *member* for more than any amount recovered. The *contract holder* may choose to have *Capital* pursue these rights on its behalf.

Workers' Compensation Insurance

Employers are liable for injuries, illness, or conditions resulting from an on-the-job accident or illness. Workers' compensation insurance is the only insurance available for such occurrences. The *contract holder* denies coverage for claims where workers' compensation insurance is required.

If the workers' compensation insurance carrier rejects a claim because the injury was not work-related, the *contract holder* may consider the charges in accordance with the *coverage* available under the *group contract*. *Benefits* are not available if the workers' compensation carrier rejects a claim for any of the following reasons:

- The employee did not use the *provider* specified by the employer or the workers' compensation carrier;
- The workers' compensation timely filing requirement was not met;
- The employee has entered into a settlement with the employer or workers' compensation carrier to cover future medical expenses; or
- For any other reason, as determined by the *contract holder*.

Motor Vehicle Insurance

To the extent *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy, such *benefits* paid by the *contract holder* and provided as a result of an accidental bodily injury arising out of a motor vehicle accident are subject to coordination of benefit rules and subrogation as described in the **Coordination of Benefits (COB)** and **Subrogation** sections.

Assignment of Benefits

Except as otherwise required by applicable law, *members* are not permitted to assign any right, *benefits* or payments for *benefits* under the *group contract* to other *members* or to any other individual or entity. Further, except as required by applicable law, *members* are not permitted to assign their rights to receive payment or to bring an action to enforce the *group contract*, including, but not limited to, an action based upon a denial of *benefits*.

Payments Made In Error

We reserve the right to recoup from the *member* or *provider*, any payments made in error, whether for a *benefit* or otherwise.

APPEAL PROCEDURES

This section explains your right to appeal a decision we make about the benefits under your vision *coverage*.

To Appeal an Adverse Benefit Determination

An adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) under your *coverage* with us for a service:

- Based on a determination of your eligibility to enroll under the *group contract*;
- Not provided because it is determined to be *investigational* or not of *optical necessity*.

If you disagree with an adverse benefit determination with respect to *benefits* available under this coverage, you may seek review of the adverse benefit determination by submitting a written appeal within 180 days of receipt of the adverse benefit determination.

Your appeal must be sent to:

National Vision Administrators
1200 Route 46 West
Clifton, NJ 07013

You have the right to submit written comments, documents, records, and other information relating to your claim for *benefits*. You also have the right to receive, upon request and free of charge, copies of all documents, records, and other information related to your adverse benefit determination. A request for information does **not** constitute an appeal. To receive copies of this information, requests should be mailed to the above listed address.

If the notice of an adverse benefit determination advises you to submit additional information in order to perfect the claim, then you should arrange to submit all requested information if and when you file an appeal. Failure to promptly submit any additional information may result in the denial of your appeal.

The following time frames apply to our review of your appeal. We will notify you of our decision within:

- 60 days of receiving your appeal if the appeal involves a vision claim and you file the appeal after receiving the vision service.
- 30 days of receiving your *a*ppeal if you file the appeal prior to receiving the vision service.

If your coverage is an employer-sponsored group plan subject to ERISA (collectively, the Employee Retirement Income Security Act of 1974 and its related regulations, each as amended) and if you remain dissatisfied upon completion of the mandatory appeal process described above, you have the right to bring a civil action under ERISA Section 502(a).

Designating an Individual to Act On Your Behalf

You may designate another individual to act on your behalf in pursuing a *benefit* claim or appeal of an unfavorable *benefit* decision.

To designate an individual to serve as your “authorized representative”, you must complete, sign, date, and return a Member Authorization Form. You may request this form from our Member Service department at **1-800-905-4102**.

We communicate with your authorized representative only after we receive the completed, signed, and dated authorization form. Your authorization form will remain in effect until you notify us in writing that the representative is no longer authorized to act on your behalf, or until you designate a different individual to act as your authorized representative.

GENERAL PROVISIONS

Benefits are Nontransferable

No person other than a *member* is entitled to receive payment for *benefits* to be furnished by *Capital* under the *group contract*. Such right to payment for *benefits* is not transferable.

Changes

By this *Benefits Booklet*, the *contract holder* makes *this coverage* available to eligible *members*. However, this *Benefits Booklet* shall be subject to amendment, modification, and termination in accordance with any provision hereof or by mutual agreement between us and *contract holder* without the consent or concurrence of the *members*. By electing us or accepting our *benefits*, all *members* legally capable of contracting, and the legal representatives of all *members* incapable of contracting, agree to all terms, conditions, and provisions hereof.

Changes in State or Federal Laws and/or Regulations and/or Court or Administrative Orders

Changes in state or federal law or regulations or changes required by court or administrative order may require *Capital* to change *coverage* for *benefits* and any *cost sharing amounts*, or otherwise change *coverage* for *benefits* in order to meet new mandated standards. Moreover, local, state, or federal governments may impose additional taxes or fees with regard to *coverages* under this *contract*. Changes in *coverage* for *benefits* or changes in taxes or fees may result in upward adjustments in cost of *coverage* to reflect such changes. Such adjustments may occur on the earlier of either the *group contract* renewal date or the date such changes are required by law.

Capital will provide the *contract holder* with an *official notice of change* at least 60 days prior to the effective date of any change in coverage for *benefits.* However, if such change occurred due to a change in law, regulation or court or administrative order which makes the provision of such notice within 60 days not possible, *Capital* will provide such notice to the *contract holder* as soon as reasonably practicable.

Discretionary Changes by Capital

Capital may change *coverage* for *benefits* and any *member* portion of cost, or otherwise change *coverage* upon the renewal of the *group contract*.

Capital will provide the *contract holder* with an *official notice of change* at least 60 days prior to the effective date of any change in coverage for *benefits.*

In the future, should terms and conditions associated with this coverage change, updates to these materials will be issued. These updates must be kept with this document to ensure the *member's* reference materials are complete and accurate.

Notwithstanding the above, changes in *Capital's* administrative procedures, including but not limited to changes in policy or underwriting guidelines, are not *benefit* changes and are, therefore, not subject to these notice requirements.

Conformity With Statues

The parties recognize that the *group contract* at all times is subject to applicable federal, state and local law. The parties further recognize that the *group contract* is subject to amendments in such laws and regulations and new legislation.

Any provisions of law that invalidate or otherwise are inconsistent with the terms of this *coverage* or that would cause one or both of the parties to be in violation of the law, is deemed to have superseded the terms of this *coverage*; provided that the parties exercise their best efforts to accommodate the terms and intent of the *group contract* consistent with the requirements of law.

In the event that any provision of the *group contract* is rendered invalid or unenforceable by law, or by a regulation, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of the *group contract* remain in full force and effect.

Choice of Forum

The *contract holder* and *members* hereby irrevocably consent and submit to the jurisdiction of the federal and state courts within Dauphin County, Pennsylvania and waive any objection based on venue or forum non conveniens with respect to any action instituted therein arising under the *group contract* whether now existing or hereafter and whether in contract, tort, equity, or otherwise.

Choice of Law

All issues and questions concerning the construction, validity, enforcement, and interpretation of the *group contract* is governed by, and construed in accordance with, the laws of the Commonwealth of Pennsylvania, without giving effect to any choice of law or conflict of law rules or provisions, other than those of the federal government of the United States of America, that would cause the application of the laws of any jurisdiction other than the Commonwealth of Pennsylvania.

Choice of Provider

The choice of a *provider* is solely the *member's*. *Capital* does not furnish *benefits* but only makes payment for *benefits* received by *members*. *Capital* is not liable for any act or omission of any *provider*. *Capital* has no responsibility for a *provider's* failure or refusal to render *benefits* or services to a *member*. The use or non-use of an adjective such as in-network or out-of-network in describing any *provider* is not a statement as to the ability, cost or quality of the *provider*.

Capital cannot guarantee continued access during the term of the *member's* enrollment to a particular *provider*. If the *member's in-network provider* ceases to be in-network, *Capital* will provide access to other *providers* with similar training and experience.

Clerical Error

Clerical error, whether of the *contract holder* or *Capital*, in keeping any record pertaining to the *coverage* hereunder, will not invalidate *coverage* otherwise validly in force or continue *coverage* otherwise validly terminated.

Entire Agreement

The *group contract* sets forth the terms and conditions of coverage of *benefits* under this Pennsylvania Preferred Provider Organization ("PPO") program that is administered by *Capital* and offered by the *contract holder* to *subscribers* and their *dependents* due to the *subscriber's* relationship with the *contract holder*. The *group contract* (including all of its attachments) and any riders or amendments to the *group contract* constitute the entire agreement between the *contract holder* and *Capital*. If there is a conflict of terms between the *group policy* and the *Certificate of Coverage*, the terms of the *group policy* shall control and be enforceable over the terms of the *Certificate of Coverage*.

Exhaust Administrative Remedies First

Neither the *contract holder* nor any *member* may bring a cause of action in a court or other governmental tribunal (including, but not limited to, a Magisterial District Justice hearing) unless and until all administrative remedies described in the *group contract* have first been exhausted.

Failure to Enforce

The failure of either *Capital*, the *contract holder*, or a *member* to enforce any provision of the *group contract* shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of the *group contract* shall not be deemed or construed to be a waiver of such default.

Failure to Perform Due to Acts Beyond Capital's Control

The obligations of *Capital* under the *group contract* including this *Benefits Booklet* shall be suspended to the extent that *Capital* is hindered or prevented from complying with the terms of the *group contract* because of labor disturbances (including strikes or lockouts); acts of war; acts of terrorism, vandalism, or other aggression; acts of God; fires, storms, accidents, governmental regulations, impracticability of performance or any other cause whatsoever beyond its control. In addition, *Capital's* failure to perform under the *group contract* shall be excused and shall not be cause for termination if such failure to perform is due to the *contract holder* undertaking actions or activities or failing to undertake actions or activities so that *Capital* is or would be prohibited from the due observance or performance of any material covenant, condition, or agreement contained in the *group contract.*

Gender

The use of any gender herein shall be deemed to include the other gender, and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).

ID Cards

Capital provides *ID cards* to all *subscribers* and other *members* as appropriate. For purposes of identification and specific coverage information, a *ID card* must be presented when service is requested.

ID cards are the property of *Capital* and should be destroyed when a *member* no longer has *coverage*. Upon request, *ID cards* must be returned to *Capital* within 31 days of the end of a *member's* coverage. *ID cards* are for purposes of identification only and do not guarantee eligibility to receive *benefits*.

Legal Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Notwithstanding the foregoing, *Capital* does not waive or otherwise modify any defense, including the defense of the statute of limitations, applicable to the type or theory of action or to the relief being sought, including but not limited to the statute of limitations applicable to actions in tort.

Notices

Any and all notices under the *group contract* shall be given in writing and addressed as follows:

- If to a *member*: to the latest electronic and/or physical address reflected in *Capital's* records.
- If to the *contract holder*: to the latest electronic and/or physical address provided by the *contract holder* to *Capital*.
- If to *Capital*: to PO Box 772132, Harrisburg, PA 17177-2132.

Member's Payment Obligations

A *member* has only those rights and privileges specifically provided in the *group contract*. Subject to the provisions of the *group contract*, a *member* is responsible for payment of any amount due to a *provider* in excess of the *benefit* amount paid by *Capital*. If requested by the *provider*, a *member* is responsible for payment of *cost sharing amounts* at the time service is rendered.

Payments

Capital is authorized by the *member* to make payments directly to *in-network providers* furnishing services for which *benefits* are provided under the *group contract*. In addition, *Capital* is authorized by the *member* to make payments directly to a state or federal governmental agency or its designee whenever *Capital* is required by law or regulation to make payment to such entity.

Once a *provider* renders services, *Capital* will not honor *member* requests not to pay claims submitted by the *provider*. *Capital* will have no liability to any person because of its rejection of the request.

Payment of *benefits* is specifically conditioned on the *member's* compliance with the terms of the *group contract*.

Policies and Procedures

Capital may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this *Benefits Booklet*, with which *members* shall comply.

Relationship of Parties

Healthcare *providers* maintain direct relationship with *members* and are solely responsible to *members* for all medical and/or vision services. The relationship between *Capital* and healthcare *providers* is an independent contractor relationship. Healthcare *providers* are not agents or employees of *Capital*, nor

is any employee of *Capital* an employee or agent of a healthcare *provider*. *Capital* shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the *member* while receiving care from any healthcare *provider*.

Neither the *contract holder* nor any *member* is an agent or representative of *Capital* and neither is liable for any acts or omissions of *Capital* for the performance of services under the *group contract*.

The *contract holder* is the agent of the *members*, not of *Capital*.

Certain services, including administrative services, relating to the *benefits* provided under the *group contract* may be provided by *Capital* or other companies under contract with *Capital*, Capital Blue Cross, or Keystone Health Plan Central.

Waiver of Liability

Capital shall not be liable for injuries or any other harm or loss resulting from negligence, misfeasance, nonfeasance or malpractice on the part of any *provider*, whether an in-network *provider* or *out-of-network provider*, in the course of providing *benefits* for *members*.

Workers' Compensation

The *group contract* is NOT in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Public Health Emergency

In the event that Capital reasonably determines that there is a public health emergency, such as but not limited to, a pandemic or natural disaster, Capital may, but is not required to, waive or modify term(s) of the contract related to the application of clinical management programs, member cost share, provisions related to the use of an in-network provider or pharmacy, or such other terms in order to reduce the cost of or to expedite the provision of care. Capital will provide notice of such change as circumstances allow.

Physical Examination

Capital at its own expense shall have the right and opportunity to examine the person of the *member* when and often as it may reasonably require during the pendency of a claim.

Applicable Group Numbers

00501114 Vision Plan 1

January, 2025