

Vision Benefits Program



**Benefits underwritten or administered by QCC Ins. Co., a subsidiary of Independence Blue Cross ®
Independent Licensees of the Blue Cross and Blue Shield Association.**

QCC Insurance Company
(Hereafter called "The Carrier")

(Hereafter called "The Contractholder")

Vision Care Program

QCC Insurance Company
(Hereafter called "the Carrier")

Group Health Benefits Booklet/Certificate

The Carrier certifies that Employees in an eligible class of the Group are entitled to the benefits described in this Booklet/Certificate, subject to the eligibility and effective date requirements of the Group Contract.

This Booklet/Certificate replaces any and all Booklet/Certificates previously issued by the Carrier providing the types of benefits described in this Booklet/Certificate.

The Contract is between the Carrier and the Contractholder. This Booklet/Certificate is a summary of the Contract provisions that affect your insurance. All benefits and exclusions are subject to the terms of the Group Contract.

BY

A handwritten signature in black ink that reads "John R. Janney". The signature is written in a cursive style with a large initial 'J' and 'R'.

John R. Janney
Sr. Vice President
Marketing Services

Vision Care Coverage

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Section 1- Defined Terms

For the purposes of this Booklet, the terms below have the following meaning:

ACCREDITED EDUCATIONAL INSTITUTION – a publicly or privately operated academic institution of higher learning which: (a) provides recognized course or courses of instruction and leads to the conference of a diploma, degree, or other recognized certification of completion at the conclusion of the course of study; and (b) is duly recognized and declared as such by the appropriate authority of the state in which such institution is located; provided, however, that in addition to any state recognition, the institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education. The definition may include, but is not limited to, colleges and universities, and technical or specialized schools.

BENEFIT PERIOD - the specified period of time during which charges for Covered Services must be Incurred in order to be eligible for payment by the Carrier. A charge shall be considered Incurred on the date the service or supply was provided to a Covered Person.

BILLED CHARGE - an amount billed by a Supplier or Professional Provider for treatment, services or supplies rendered to a Covered Person.

COINSURANCE - a specific percentage of the Provider's Reasonable Charge for Covered Services set forth in the SCHEDULE OF BENEFITS, for which the Covered Person is responsible.

- A. Program Coinsurance - a specified percentage of the Provider's Reasonable Charge applied to all Covered Services for which the Covered Person is responsible.
- B. Benefit Coinsurance - a specified percentage of the Provider's Reasonable Charge applied to a specific Covered Service for which the Covered Person is responsible.

CONTRACT - the Group Policy of Vision Care Benefits, including the Group Application, riders and/or endorsements, if any, between the Carrier and the Group, also referred to as the Group Contract.

CONTRACTHOLDER - any individual, corporation or other entity who, as the representative of an enrolled group of Employees (Members) and as Agent for the Members is acceptable to the Carrier. The Contractholder has agreed to pay the charges payable under the Contract to the Carrier and to receive any information from the Carrier on behalf of the Applicants.

COPAYMENT - a specified amount of expenses applied to a specific Covered Service for which the Covered Person is responsible per Covered Service.

COVERED PERSON - an enrolled Employee or Member and his or her Eligible Dependents who have satisfied the specifications under the “WHO IS COVERED” section of this Booklet-Certificate.

COVERED SERVICE - a service or supply specified in this Booklet/Certificate for which benefits will be provided when rendered by a Professional Provider or Supplier. For purposes of this coverage, the term “Covered Materials” means Covered Services, with the exception of Eye Examination and Refractive Services.

DEPENDENT - a Covered Person other than the Employee or Member as specified in the Schedule of Eligibility.

EFFECTIVE DATE - a date on which coverage for a Covered Person begins under the Group Contract.

EMPLOYEE/MEMBER - an individual in the Group who meets the eligibility requirements for enrollment who is so specified for enrollment and in whose name the identification card is issued.

EYE EXAMINATION AND REFRACTIVE SERVICES - a comprehensive examination and evaluation of the eyes performed by a physician, Ophthalmologist or Optometrist, which shall include, but not be limited to, the services listed in Paragraph "A" of the Section entitled "VISION CARE BENEFITS".

FAMILY COVERAGE - coverage for the Member and one or more of the Member's Dependents.

INCURRED - a charge shall be considered Incurred on the date a Covered Person receives the service or supply for which the charge is made.

LENS - a transparent refracting medium, usually made of plastic.

Aphakic - a lens prescribed for those who have had the crystalline lens of the eye removed during cataract surgery or who were born without a crystalline lens.

Bifocal - a lens containing two different powers, one for distance vision, and one for near vision.

Disposable Contact - a soft plastic contact lens that is applied to the eye for correcting refractive errors for a period of approximately one to two weeks and is then discarded.

Hard Contact - a curved glass or plastic lens that is applied to the eye for correction of refractive errors.

Lenticular - a type of aphakic lens prescribed to replicate the crystalline lens of the eye.

Single Vision - a lens with one correction, for either distance or near vision.

Soft Contact - a lens for correcting refractive errors. They are of soft plastic material.

Trifocal - a lens that has three (3) distinct areas for visual focus.

LIMITATIONS - the Maximum frequency set forth in the SCHEDULE OF BENEFITS, at which a Covered Service is allowed.

MAXIMUM - the greatest amount payable by the Carrier set forth in the SCHEDULE OF BENEFITS, for Covered Services. This could be expressed in dollars or a specified number of services for a specified period of time.

A. Program Maximum - the greatest amount payable by the Carrier for Covered Services.

B. Benefit Maximum - the greatest amount payable by the Carrier for a specific Covered Service.

NON-PARTICIPATING PROVIDER - a Provider that does not participate in the Carrier's programs and is not required to accept the Carrier's payment as payment-in-full.

OPHTHALMOLOGIST - is a physician who specializes in the diagnosis, treatment and prescription of medications and lenses related to conditions of the eye, and who may perform Eye Examination and Refractive Services.

OPTICIAN - is a person who makes, fits, supplies and adjusts eyeglasses in accordance with a prescription written by a Professional Provider to correct a patient's optical defects. Opticians are not Professional Providers.

OPTOMETRIST - is a person licensed to practice optometry in accordance with the provisions of the Optometric Practice and Licensure Act, and who may perform Eye Examination and Refractive Services.

PARTICIPATING PROVIDER - a Provider that has an agreement with the Carrier pertaining to payment for Covered Services rendered to a Covered Person.

PHYSICIAN - a person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed and legally entitled to practice medicine in all of its branches, perform surgery and dispense drugs.

PROFESSIONAL PROVIDER - a person or practitioner licensed where required and performing within the scope of such license. The Professional Providers include:

- Doctor of Ophthalmology
- Doctor of Optometry
- Doctor of Medicine
- Doctor of Osteopathy
- Physician

PROVIDER'S REASONABLE CHARGE - the dollar amount on which a Covered Person's Coinsurance, Benefit Maximums and benefits will be calculated. "Provider's Reasonable Charge" shall mean the following:

- i. For services rendered by a Participating Provider, "Provider's Reasonable Charge" means the rate of reimbursement for Covered Services determined by contract, or the Billed Charge, whichever is less;
- ii. For services rendered by a Non-Participating Provider, "Provider's Reasonable Charge" means the Reasonable and Customary Charges, or Benefit Maximum amount, or, Billed Charge, whichever is less.

SUPPLIER - a provider engaged in dispensing ophthalmic material (e.g., contact lenses, standard lenses) in accordance with a prescription written by a Professional Provider. Suppliers include, but are not limited to, Opticians and retail optical dispensing firms.

TOTAL DISABILITY - except as otherwise specified in this Booklet-Certificate, a Member who, due to illness or injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Member or Dependent must be under the regular care of a Physician.

Section 2 - Who Is Covered

Eligible Person

Eligible Person and Eligible Dependent shall have the same meaning as in The Vanguard Group, Inc. Benefit Plan Summary Plan Description (the “SPD”).

Effective Date

The date that the Group agrees that all Eligible Persons may apply and become covered.

Schedule Of Covered Services

Covered Services	Amounts Payable And Limitations On Covered Services	
	Participating*	Non-Participating
Eye examination and Refraction - payable for one service every Benefit Period.	100% of the Provider's Reasonable Charge.	100% of the Provider's Reasonable Charge, up to a Maximum of \$40 per Benefit Period.

At a participating or non-participating provider, a member may choose, any one of the following, per benefit period:

- Two (2) pairs of eyeglasses (frames/lenses), or two pairs of contact lenses (up to \$200 per pair), or disposable contact lenses (up to \$200)
- One (1) pair of glasses, and one (1) pair of contact lenses (up to \$200) or One (1) pair of glasses and disposable contact lenses (up to \$200) within the calendar year of the benefit.

Frames - Plan supplied:	100% up to a \$100 value **, with a Copayment of:	100% up to a Benefit Period Maximum of \$64.00 for all frames.
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- Fashion selection \$0
- Designer selection \$0
- Premier selection \$0

Doctor Supplied 100%, up to a Maximum of \$100.00

**** As a value-added enhancement to the \$100 retail frame allowance, additional choice of frames are available.**

Standard Lenses (per pair):
Plastic or glass,

- | | | |
|--|------|-------------------------------|
| ○ Single vision, | 100% | 100%, up to a Maximum of \$30 |
| ○ Bifocal, | 100% | 100%, up to a Maximum of \$40 |
| ○ trifocal, | 100% | 100%, up to a Maximum of \$60 |
| ○ Aphakic, Lenticular or
Oversized. | 100% | 100%, up to a Maximum of \$80 |

Covered Services (Continued)

Amount Payable And Limitations On Covered Services

	Participating*	Non-Participating
Standard Lenses (Continued):	100%, with a Copayment of:	See Below
o Glass grey #3 prescription suns.	\$0	Not covered
o Tinting	\$0	Not covered
o Blended Invisible bifocals	\$10.00	Not covered
o Ultraviolet (UV) coating	\$12.00	Not covered
o Scratch-resistant coating:		
- single vision	\$15.00	Not covered
- multifocal	\$25.00	Not covered
o Anti-reflective coating		
- standard	\$33.00	Not covered
- premium	\$48.00	Not covered
- ultra	\$60.00	Not covered
o Intermediate	\$30.00	Not covered
o Progressive additional lenses:		
- Standard	\$0	100%, up to a Maximum of \$130
- Premium	\$40.00	100%, up to a Maximum of \$130
- Multifocal (digital or free-form)	\$40.00	Standard Lens Reimbursement
o Polaroid	\$60.00	Standard Lens Reimbursement
o Polycarbonate (adult)	\$30.00	Standard Lens Reimbursement
o Polycarbonate (under age 19)		
--Single vision,	100%	100%, up to a Maximum of \$70
--Bifocal,	100%	100%, up to a Maximum of \$80
--Trifocal,	100%	100%, up to a Maximum of \$95
o High Index	\$55.00	Standard Lens Reimbursement
o Photochromic glass:		
- single vision	\$15.00	Not covered
- multifocal	\$25.00	Not covered
o Photochromic plastic:		
- single vision	\$60.00	Not covered
- multifocal	\$70.00	Not covered
Contact Lenses (in lieu of eyeglasses):		
--Evaluation and Fitting	100%	100% up to a maximum of \$35
--Medically necessary	100%	100%, up to a maximum of \$200
--Disposable (unlimited boxes)	100%, up to a maximum of \$200	100%, up to a maximum of \$200
--Conventional (per pair)	100%, up to a maximum value of \$200	100%, up to a maximum of \$200

NOTE: At non-participating providers, members pay 100% of charges for vision care options.

Section 4 - Vision Care Benefits

Covered Services

Subject to the Exclusions, conditions, and Limitations set forth in this Booklet/Certificate, a Covered Person is entitled to the benefits of this benefit section for Covered Services rendered by a Professional Provider or Supplier, unless otherwise indicated, in the amounts specified in the Schedule of Benefits.

This program allows you to maximize your Vision Care benefits by utilizing Participating Providers. When you go to a Participating Provider for an eye examination, you are assured of little or no out-of-pocket cost. When you purchase vision care hardware, such as frames and standard lenses or contact lenses, from a Participating Provider/Supplier, you may have no out-of-pocket costs, depending on your choice of hardware. The program requires a copayment amount for the purchase of some specialty hardware supplies, as shown in the Schedule of Benefits. However, using Participating Providers will lower your out-of-pocket costs and allow you to purchase most vision care hardware at fixed, reduced prices. You will receive a listing of the Providers that participate in the QCC Insurance Company's Vision Care Program.

The program also provides benefits if you choose to use Non-Participating Providers and Suppliers. Benefits are payable up to the Benefit Period Maximum amounts shown in the Schedule of Benefits for eye examinations and vision care hardware provided by Non-Participating Providers.

The Benefit Period Maximum amount shown in the Schedule of Benefits is applicable to either all Participating Covered Services or all Non-Participating Covered Services per Benefit Period.

Professional Services

A. Eye Examination And Refractive Services:

Such services, performed by a Professional Provider, as defined in Schedule of Covered Services Section, shall include, but are not limited to:

1. Case history
2. Visual acuity, near and far.
3. External examination, including biomicroscopy or other magnified evaluation of the anterior chamber.
4. Objective, subjective and ophthalmoscopic examinations.
5. Binocular measure.
6. Summary, findings, and recommendations.

B. Hardware

1. Contact Lens Prescription And Fitting Services:

Such services, performed by a Professional Provider shall include, but are not necessarily limited to:

1. Keratometry, or "K" reading, through the use of a keratometer to determine measurements of the eyes, curvature and base curve.
2. Proper fitting of appropriate contact lenses, including the training of insertion and removal of trial contact lenses to the patient's corneas.
3. Post-dispensing contact lens follow-up care, including correction of any ill-fitting or unsuitable lenses.

Contact Lens Prescription and Fitting Services must be preceded by Eye Examination and Refraction Services as described in Paragraph A above.

2. Post-Refractive Services

Post-refractive Services consist of the ordering of lenses and frames (facial measurements, lenticular formula and other specifications), cost of the materials, verification of the completed prescription upon return from the laboratory, adjustment of the completed eyeglasses to the patient's face and the subsequent servicing (e.g., refitting, realigning, readjusting, tightening).

Limitations

1. In cases involving Covered Services in which the Professional Provider or Supplier and Covered Person elect to utilize photogrey or light sensitive lenses, the program will provide benefits, but will not provide any additional allowance in excess of those delineated in the Schedule of Benefits providing the Covered Person qualifies for such benefits.
2. Payment for frames, standard lenses and/or contact lenses will be made only if prescribed by a Professional Provider or Supplier.

Section 5 - What Is Not Covered

Except as specifically provided in this Booklet/Certificate, no benefits will be provided for services, supplies or charges:

- For examinations or materials which are not listed herein as a Covered Service;
- For any lenses which do not require a prescription;
- For an eye examination without a refraction;
- For replacement of lost, stolen, broken or damaged lenses, contact lenses or frames unless the Covered Person would otherwise meet the frequency limitations. However, this does not apply to plan-supplied frames and standard lenses obtained from a Participating Provider if breakage occurs during normal use within 365 days of the dispensing date;
- For the cost of any insurance premiums indemnifying the Covered Person against losses for lenses or frames;
- For sunglasses not requiring a prescription; VDT eyeglasses, safety eyeglasses and safety goggles;
- For medical attention or surgical treatment of the eye;
- For diagnostic services, such as diagnostic X-rays, cardiographic, encephalographic examinations and pathological or laboratory tests;
- For drugs or any other medications;
- For procedures, such as but not limited to, orthoptics, vision therapy, subnormal vision aids, and tonography;
- For eye examinations or materials sponsored by the Covered Person's employer without charge to the Covered Person;
- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Covered Person claims the benefits or compensation, unless the Covered Person is an owner or executive officer and claims an exemption permitted by law;
- For which a Covered Person would have no legal obligation to pay;
- Received from a medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- Incurred prior to the Covered Person's Effective Date;
- Incurred after the date of termination of the Covered Person's coverage except for lenses and frames prescribed prior to such termination and delivered within 30 days from such date;
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- For duplicate and temporary devices, appliances, and services. This Exclusion does not apply to disposable contact lenses;
- For which the Covered Person incurs no charge;

- In a facility performed by a Professional Provider or Supplier who in any case is compensated by the facility for similar Covered Services performed for patients;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan;
- For any loss sustained or expenses Incurred during military services while on active duty; or as a result of an act of war, whether declared or undeclared;
- To the extent payment has been made under Medicare Part B when Medicare is primary or would have been made if the Covered Person had applied for Medicare and claimed Medicare benefits; however, this Exclusion shall not apply when the Group is obligated by law to offer the Covered Person all the benefits of the Contract and the Covered Person so elects this coverage as primary;
- For low vision aids;
- For eyeglass frames and contact lenses dispensed within the same Benefit Period by a Participating Provider;
- Other than specifically provided in the Vision Care Benefits section of this Booklet-Certificate.

Section 6 - General Information

Benefits To Which Covered Persons Are Entitled

1. The liability of the Carrier is limited to the benefits specified in the Group Contract.
2. No person other than a Covered Person is entitled to receive benefits under this benefit programs.
3. Benefits for Covered Services will be provided only for services and supplies that are rendered by a Provider specified in the DEFINED TERMS section of this Booklet-Certificate.

Termination Of Coverage At Termination Of Employment Or Membership In The Group

When a Covered Person ceases to be an Eligible Employee or Eligible Dependent, or the required contribution is not paid, the Covered Person's coverage will terminate at the end of the last month for which payment was made. However, if benefits under this coverage are provided by and/or approved by the Carrier before the Carrier receives notice of the Covered Person's termination under the Group Contract, the cost of such benefits will be the sole responsibility of the Covered Person. In that circumstance, the Carrier will consider the effective date of termination of a Covered Person under the Group Contract to be not more than 60 days before the first day of the month in which the Group notified the Carrier of such termination.

Continuation Of Coverage At Termination Of Employment Or Membership Due To Total Disability

A Covered Person's benefits under this benefit program may be extended after the date that person ceases to be a Covered Person under the Group Contract because of termination of employment or termination of membership in the Group. It will be extended if, on that date, the person is Totally Disabled from an illness or injury. The extension is only for that illness or injury and any related illness or injury. It will be for the time the person remains Totally Disabled from any such illness or injury, but not beyond twelve months if the person ceases to be a Covered Person because the Group Contract ends.

The Carrier will provide benefits under the Group Contract during an extension as if the person were still a Covered Person. In addition, coverage will apply only to the extent that other coverage for the Covered Services is not provided for you through the Carrier by the Group. Continuation of coverage is subject to payment of the applicable premium.

When You Terminate Employment - Continuation Of Coverage Provisions - Cobra

For purposes of this subsection of your booklet/certificate, "qualified beneficiary" means any person who, on the day before any event which would qualify him or her for continuation under this subsection, is covered for group health benefits under this Plan as:

- a. you, an active, covered Employee;
- b. your spouse; or
- c. your Dependent child.

In addition, any child born to or placed for adoption with you during COBRA continuation will be a qualified beneficiary.

Any person who becomes covered under this Plan during COBRA continuation, other than a child born to or placed for adoption with you during COBRA continuation, will not be a qualified beneficiary.

If An Employee Terminates Employment or Has a Reduction of Work Hours

If your group benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if:

- a. your termination of employment was not due to gross misconduct; and
- b. you are not entitled to Medicare.

The continuation will cover you and any other qualified beneficiary who loses coverage because of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, subject to the “When Continuation Ends” paragraph of this subsection.

Extra Continuation for Disabled Qualified Beneficiaries

If a qualified beneficiary is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the day before the qualified beneficiary's health benefits would otherwise end due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours or within 60 days of that date, the qualified beneficiary and any other affected qualified beneficiaries may elect to extend the 18 month continuation period described above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Plan Administrator must be given written proof of Social Security's determination of the qualified beneficiary's disability before the earlier of:

- a. The end of the 18 month continuation period; and
- b. 60 days after the date the qualified beneficiary is determined to be disabled.

If, during the 11 month continuation period, the qualified beneficiary is determined to be no longer disabled under the United States Social Security Act, the qualified beneficiary must notify the Plan Administrator within 30 days of such determination, and continuation will end, as explained in the “When Continuation Ends” paragraph of this subsection.

If an Employee Dies

If you die, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the “When Continuation Ends” paragraph of this subsection.

If an Employee's Marriage Ends

If your marriage ends due to legal divorce or legal separation, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the “When Continuation Ends” paragraph of this subsection.

If an Employee Becomes Entitled to Medicare

If you become entitled to Medicare after terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months from the date the initial 18 month continuation period started, subject to the “When Continuation Ends” paragraph of this subsection.

If you become entitled to Medicare before terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours and, during the subsequent 18-month period, you terminate employment (for reasons other than gross misconduct) or have a reduction of work hours, all qualified beneficiaries other than you whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 18 months, but may be extended until 36 months from the date you became entitled to Medicare, subject to the “When Continuation Ends” paragraph of this subsection.

If a Dependent Loses Eligibility

If your Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this booklet/certificate, other than your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified beneficiary. The continuation can last for up to 36 months, subject to the "When Continued Ends" paragraph of this subsection.

Concurrent Continuations

If your Dependent who is a qualified beneficiary elects to continue his or her group health benefits due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above.

The 36 month continuation period starts on the date the initial 18 month continuation period started, and the two continuation periods will run concurrently.

The Qualified Beneficiary's Responsibilities

A person eligible for continuation under this subsection must notify the Plan Administrator, in writing, of:

- a. your legal divorce or legal separation from your spouse; or
- b. your Dependent child's loss of dependent eligibility, as defined in this booklet/certificate.

The notice must be given to the Plan Administrator within 60 days of either of these events.

In addition, a disabled qualified beneficiary must notify the Plan Administrator, in writing, of any final determination that the qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act. The notice must be given to the Plan Administrator within 30 days of such final determination.

The Employer's Responsibilities.

Your Employer must notify the Plan Administrator, in writing, of:

- a. your termination of employment (for reasons other than gross misconduct) or reduction of work hours;
- b. your death; or
- c. your entitlement to Medicare.

The notice must be given to the Plan Administrator within 60 days of any of these events.

The Plan Administrator's Responsibilities

The Plan Administrator must notify the qualified beneficiary, in writing, of:

- a. his or her right to continue the group health benefits described in this booklet/certificate;
- b. the monthly premium he or she must pay to continue such benefits; and
- c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified beneficiary within 14 days of:

- a. the date the Employer notifies the Plan Administrator, in writing, of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, your death, or your entitlement to Medicare; or
- b. the date the qualified beneficiary notifies the Plan Administrator, in writing, of your legal divorce or legal separation from your spouse, or your Dependent child's loss of eligibility.

The Employer's Liability

Your Employer will be liable for the qualified beneficiary's continued group health benefits to the same extent as, and in the place of, the Plan, if:

- a. the Employer fails to remit a qualified beneficiary's timely premium payment to the Plan on time, thereby causing the qualified beneficiary's group health benefit to end; or
- b. the Plan Administrator fails to notify the qualified beneficiary of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified beneficiary must give the Plan Administrator written notice that he or she elects to continue benefits under the coverage. This must be done within 60 days of the date a qualified beneficiary receives notice of his or her continuation rights from the Plan Administrator as described above or 60 days of the date the qualified beneficiary's group health benefits end, if later. Furthermore, the qualified beneficiary must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Plan Administrator by the qualified beneficiary, in advance, at the time and in the manner set forth by the Plan Administrator. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified beneficiary stayed insured under this benefit plan on a regular basis. It includes any amount that would have been paid by the Employer. An additional charge of two percent of the total premium charge may also be required by the Employer.

Qualified beneficiaries who receive the extended coverage due to disability described above may be charged an additional 50% of the total premium charge during the extra 11 month continuation period.

If the qualified beneficiary fails to give the Plan Administrator notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment in Premiums

A qualified beneficiary's premium payment is timely if, with respect to the first payment after the qualified beneficiary elects to continue, such payment is made no later than 45 days after such election. In all other cases, the premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified beneficiary's continued group health benefits under this coverage ends on the first to occur of the following:

- a. with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- b. with respect to a disabled qualified beneficiary and his or her family members who are qualified beneficiaries who have elected an additional 11 months of continuation, the earlier of:
 - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
 - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act;

- c. with respect to continuation upon your death, your legal divorce or legal separation, or the end of your covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- d. with respect to your Dependent whose continuation is extended due to your entitlement to Medicare,
 - after your termination of employment or reduction of work hours, the end of the 36 month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours; and
 - before, your termination of employment or reduction of work hours where, during the 18-month period following Medicare entitlement, you terminate employment or have a reduction of work hours, at least to the end of the 18 month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours, but not less than 36 months from the date you become entitled to Medicare.
- e. the date this coverage ends;
- f. the end of the period for which the last premium payment is made;
- g. the date he or she becomes covered under any other group health plan (as an employee or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which he or she satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
- h. the date he or she becomes entitled to Medicare.

THE PLAN'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER THIS COVERAGE ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION OF YOUR BOOKLET/CERTIFICATE.

THE PLAN IS NOT THE PLAN ADMINISTRATOR UNDER THE COVERAGE OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS PLAN ADMINISTRATOR, THE PLAN ADMINISTRATOR SHALL BE THE EMPLOYER.

Continuation Of Incapacitated Child

If your unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on you for over half of his support, you may apply to the Carrier to continue coverage of such child under this coverage upon such terms and conditions as the Carrier may determine. Coverage of such Dependent child shall terminate upon his or her marriage. Continuation of benefits under this provision will only apply if the child was eligible as a Dependent and mental or physical incapacity commenced prior to the limiting age under the coverage.

The child must be unmarried, incapable of self-support and the disability must have commenced prior to attaining the limiting age. The disability must be certified by the attending physician; furthermore, the disability is subject to annual medical review. In a case where a handicapped child is over the limiting age and joining the Carrier for the first time, the handicapped child must have been covered under the prior carrier and submit proof from the prior carrier that the child was covered as a handicapped person.

Timely Filing

The Carrier will not be liable under this coverage unless proper notice is furnished to the Carrier that Covered Services have been rendered to a Covered Person. Written notice must be given within 20 days after completion of the Covered Services. The notice must include the date and information required by the Carrier to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

Your failure to give notice to the Carrier within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Carrier be required to accept notice more than two years after the end of the Benefit Period in which the Covered Services are rendered.

Release Of Information

Each Covered Person agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this Plan may furnish to the Carrier, upon its request, any information (including copies of records relating to the illness or injury). In addition, the Carrier may furnish similar information to other entities providing similar benefits at their request.

The Carrier may furnish other plans or plan sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

When the Carrier needs to obtain consent for the release of personal health information, authorization of care and treatment, or to have access to information from a Covered Person who is unable to provide it, the Carrier will obtain consent from the parent, legal guardian, next of kin, or other individual with appropriate legal authority to make decisions on behalf of the Covered Person.

Claim Forms

The Carrier will furnish to the Covered Person making the claim, or to the Contractholder, for delivery to such Covered Person, such forms as are required for filing proof of loss.

Time Of Payment Of Claims

All benefits payable under this benefit program will be payable not more than 60 days after receipt of proof.

Right To Recover Payments In Error

If the Carrier should pay for any contractually excluded services through inadvertence or error, the Carrier maintains the right to seek recovery of such payment from the Professional Provider, Supplier or Covered Person to whom such payment was made.

Consumer Rights

Each Covered Person has the right to access, review and copy their own health and membership records and request amendments to their records. This includes information pertaining to claim payments, payment methodology, reduction or denial, medical information secured from other agents, plans or providers. For more information about accessing, reviewing or copying records call Member Services at the toll-free number on your ID card.

Limitation Of Actions

No legal action may be taken to recover benefits prior to 60 days after notice of claim has been given as specified above, and no such action may be taken later than two years after the date services are rendered.

Covered Person/Provider Relationship

1. The choice of a Provider is solely the Covered Person's.
2. The Carrier does not furnish Covered Services but only makes payment for Covered Services received by Covered Persons. The Carrier is not liable for any act or omission of any Professional Provider or Supplier. The Carrier has no responsibility for a Professional Provider's or Supplier's failure or refusal to render Covered Services to a Covered Person.

Agency Relationships

The Group is the agent of the Member, not the Carrier.

Identification Cards And Benefit Booklets/Certificates

The Carrier will provide the Identification Cards to Members or to the Group, depending on the direction of the Group. The Carrier will also provide to each Member of an Enrolled Group a benefit booklet/certificate describing the benefits provided under the Group Contract.

Applicable Law

The Contract is entered into, interpreted in accordance with, and is subject to the laws of the Commonwealth of Pennsylvania.

Member Rights

A Member shall have no rights or privileges as to the benefits provided under this coverage except as specifically provided herein.

Notice

Any notice required under the Group Contract must be in writing. Notice given to a Member will be given to the Member in care of the Group, or sent to the Member's last address furnished to the Carrier by the Group. The Group, the Carrier, or a Member may, by written notice, indicate a new address for giving notice.

Subrogation

In the event any service is provided or any payment is made to a Covered Person under this Contract, the Carrier shall be subrogated and succeed to the Covered Person's rights of recovery therefor against any person, firm, corporation, or organization except against insurers on policies of insurance issued to and in the name of the Member. The Covered Person shall execute and deliver such instruments and take such other reasonable action as the Carrier may require to secure such rights. The Member shall do nothing to prejudice the rights given the Carrier by this Article without their consent.

The Covered Person shall pay the Carrier all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided or paid under this Contract and as permitted by law.

The Carrier's right of subrogation shall be unenforceable when prohibited by law.

Coordination of Benefits

The Coordination of Benefits (COB) provision does not apply to the vision coverage described in this booklet-certificate.

Limitations Of Carrier Liability

The Carrier shall not be liable for injuries or damage resulting from acts or omissions of any Officer or Employee of the Carrier or any Professional Provider or Supplier furnishing services or supplies to the Covered Person; nor shall the Carrier be liable for injuries or damage resulting from the dissemination of information for the purpose of claims processing or facilitating patient care.

Resolving Problems

For purposes of this section only, the term “Member” replaces the term “Covered Person.”

Member Complaint Process

The Carrier has a process for Members to express informal complaints. To register a complaint (as opposed to an appeal as discussed below), Members should call the Member Services Department at the telephone number on the back of their identification card or write to the Carrier at the following address:

Independence Blue Cross
General Correspondence
1901 Market Street
Philadelphia, PA 19103

Most Member concerns are resolved informally at this level. However, if the Carrier is unable to immediately resolve the Member complaint, it will be investigated, and the Member will receive a response in writing within thirty (30) days.

Member Appeal Process

Filing an Appeal. The Carrier maintains procedures for the resolution of Member appeals. Member appeals may be filed within 180 days of the receipt of a decision from the Carrier stating an adverse benefit determination. An appeal occurs when the Member or another authorized representative requests a change of a previous decision made by the Carrier by following the procedures described here. In order to authorize someone else to be your representative for the appeal, you must complete a valid authorization form. Contact the Carrier as directed below to obtain a form for a member/enrollee to authorize an appeal by a provider or other representative or for questions regarding the requirements for an authorized representative.

The Member or other authorized person on behalf of the Member, may request an appeal by calling or writing to the Carrier, as stated in the letter notifying the Member of the decision or as follows:

Member Appeals Department	Toll Free Phone: 1-888-671-5276
P.O. Box 41820	Toll Free Fax: 1-888-671-5274 or
Philadelphia, PA, 19101-1820.	Phila. Fax: 215-988-6558

Types of Member Appeals and Timeframe Classifications

Following are the two types of Member appeals and the issues they address:

- Medical Necessity Appeal Issues – An appeal by or on behalf of a Member that focuses on issues of Medical Necessity or Medical Appropriateness and requests the Carrier to change its decision to deny or limit the provision of a Covered Service. Medical Necessity appeals include appeals of adverse benefit determinations based on the exclusions for experimental/investigative or cosmetic services.
- Administrative Appeal Issues – An appeal by or on behalf of a Member that focuses on unresolved Member disputes or objections regarding a Carrier decision that concerns coverage terms such as contract exclusions and non-covered benefits, exhausted benefits, and claims payment issues. Although an administrative appeal may present issues related to Medical Necessity and Medical Appropriateness, these are not the primary issues that affect the outcome of the appeal.

The timeframes described below for completing a review of each appeal depend on additional classifications:

- Standard Pre-service appeal - An appeal for benefits that, under the terms of the Carrier, must be pre-certified or pre-approved (either in whole or in part) before medical care is obtained in order for coverage to be available.

- Standard Post-service appeal - An appeal for benefits that is not a Pre-service appeal. (Post-service appeals concerning claims for services that the Member has already obtained do not qualify for review as expedited/urgent appeals.)
- Expedited/Urgent appeal – An appeal that provides faster review, according to the procedures described below, on a pre-service issue. The Carrier will conduct an expedited appeal on a pre-service issue when it determines, based on applicable guidelines, that delay in decision-making would seriously jeopardize the Member’s life, health or ability to regain maximum function or would subject the Member to severe pain that cannot be adequately managed while awaiting a standard appeal decision.

Information for the Appeal Review including Matched Specialist’s Report. You may submit to the Carrier additional information pertaining to your case. You may specify the remedy or corrective action being sought. Upon request at any time during the appeal process, the Carrier will provide you or your authorized representative access to, and copies of, documents, records, and other information relevant to the appeal that is provided for the appeal decisionmaker(s) to review.

Input from a matched specialist is obtained for all Medical Necessity Appeals. A matched specialist is a licensed physician or psychologist in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the adverse benefit determination at issue in the appeal and cannot be a subordinate of the person who made that determination.

Appeal Committee Composition and Role. Each Appeal Committee described below will be comprised of one to three persons designated by the Carrier to act as decisionmaker(s) on the appeal. The Committee decisionmaker(s) did not make the adverse benefit determination at issue in the appeal and are not subordinates of the person who made that determination. Each Committee will review all relevant information for the appeal, whether from the Member or his authorized representative or obtained from other sources during the investigation of the appeal issues.

Standard Appeals: Process and timeframes.

An acknowledgement letter and description of the appeal process is mailed following receipt of a Member appeal. A standard appeal consists of one level of internal review for which the evaluation and decision must be completed within the following timeframes:

- Standard Pre-service Appeal – within 30 days of receipt of the appeal request
- Standard Post-service Appeal – within 60 days of receipt of the appeal request

The appeal review will occur based on the information available for the Appeal Committee’s review. You are encouraged to supply additional relevant information to the appeals specialist preparing your appeal.

Written notice of the standard appeal decision will be sent within the timeframes stated above. If your appeal is denied, the decision notice will state the specific reason for the denial, refer to Carrier provision(s) and guidelines on which the decision is made, tell you about relevant information that is available free of charge, and describe external appeal rights or other dispute resolution options that may be available to you.

The standard appeal decision is final with respect to your right to appeal through the Carrier’s internal member appeal process.

Expedited Appeals: Process and timeframes

If your case involves a serious medical condition which you believe may jeopardize your life, health, ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed while awaiting a standard appeal decision, you may ask to have your case reviewed in a quicker manner, as an expedited appeal. An expedited appeal consists of one level of internal review for which the evaluation and decision must be completed within the following timeframe:

Expedited Pre-service Appeals - within 72 hours of receipt of the appeal request.

To request an expedited appeal by the Carrier, call or fax the Member Appeals Department at the phone numbers listed above under "Filing an Appeal." Information related to your appeal will be requested and you will be promptly informed whether it qualifies for review as an expedited appeal or must instead be processed as a standard appeal.

The Expedited Appeal Committee will review all relevant information for the appeal from the Member or his authorized representative or from other sources that is received in time to permit compliance with the time limits for review of an expedited appeal. You are encouraged to supply additional relevant information to the appeals specialist preparing your appeal.

The Expedited Appeal review will be completed promptly based on your health condition, but no later than seventy-two (72) hours after receipt of your expedited appeal by the Carrier. You will be notified of the decision by telephone and a letter mailed in no more than seventy-two (72) hours. If your appeal is denied, the decision notice will state the specific reason for the denial, refer to your coverage plan provision(s) and guidelines on which the decision is made, tell you that relevant information is available free of charge, and describe external appeal rights or other dispute resolution options that may be available to you. The expedited appeal decision is then final with respect to a Member's right to appeal through the Carrier's internal appeal process.

The policy and procedures for Member appeals may change due to changes that the Carrier makes to comply with applicable state and federal laws and regulations, to satisfy standards of certain recognized accrediting agencies, or to otherwise improve the Member Appeals process.

