Everything you need to know about your vision plan

Independence

Independence

Vision

The clear solution to your vision care needs

Use your vision benefits

Vision problems are among the most prevalent health issues in the United States. Nearly 176 million American adults wear some form of vision correction.* An eye exam can help prevent vision problems and help detect more serious chronic health conditions, such as diabetes, hypertension, and heart disease.

View your benefits online

visit ibxpress.com

Your vision plan gives you access to timely treatment and covered services like refraction, glaucoma screenings, and dilation that will help paint a picture of your overall health.

Freedom of provider choice

You have access to the Davis Vision provider network of 60,000 access points which includes ophthalmologists, optometrists, and regional and national retailers, including Visionworks.

Choose from an extensive frame collection

You can select any frame from the Davis Vision Exclusive Frame Collection of stylish, Contemporary frames covered in full, or with a minimal copay. You also have the freedom to use your frame allowance at any network location toward any frame on the market today. This includes Visionworks, which has over an average of 2,000 frames to to choose from per store.

The Davis Vision Exclusive Frame Collection features over 200 of the latest frames to mirror the fit, function, and fashion needs of today's vision care consumer. Every frame or lens purchased at a participating provider is backed by an unconditional one-year breakage warranty for repair or replacement.

Coverage for contacts and laser vision correction

You can purchase replacement contact lenses through DavisVisionContacts.com, a mail-order contact lens replacement program. If you're interested in Laser Vision Correction, you can receive up to *25 percent off* a participating provider's usual and customary fees, or *5 percent off* any participating provider's advertised specials on laser vision correction services.

You can also view your benefits online through ibxpress.com. You can:

- Check eligibility
- Locate a participating provider
- View the Davis Vision Collection of frames

DAVIS VISION
EYECARE REFRAMED™

Visionworks' retail centers offer affordability, choice, and convenience

Visionworks' optical retail centers are a cornerstone of the provider network and support Independence Blue Cross's commitment to choice. Visionworks retail centers are located across the Philadelphia five-county area, surrounding counties, and states, making it convenient to find one close to you.

Visionworks has high-quality eyeglasses, designer frames, and a wide variety of contact lenses, reading glasses, and specialty lenses all at great prices. With a dedication to quality, durability, and variety, Visionworks provides you with all you need to find the right look. Visionworks also has one of the largest selections of fun and fashionable kid's eyeglasses in the eyewear industry. Kids 13 and younger receive free impact and scratch-resistant lenses.

With your vision plan, you receive even more savings at Visionworks on items, such as:

- High-quality designer and exclusive brands frames
- Eyeglass lenses
- Contact lenses
- Sunglasses
- Vision correction

To find a Visionworks near you, go to visionworks.com.

If you have any questions about your vision benefits, call **1-800-ASK-BLUE** (TTY: 711).

*VisionWatch - The Vision Council Member Benefit Reports, The Vision Council & Jobson, 12ME September 2009

QCC INSURANCE COMPANY
(Hereafter referred to as "Company")
1901 Market Street
Philadelphia, PA 19103-1480

Individual Adult Vision Supplemental Benefit Policy

<u>This is a Limited Policy – Read it Carefully</u>

THIS IS A NON-PARTICIPATING POLICY

READ THE POLICY CAREFULLY FOR DETAILS ON THE VISION BENEFIT COVERAGE. This Policy is a legal contract between you and the Company.

NOTICE OF RIGHT TO EXAMINE POLICY: The Policyholder may return this Policy within (10) days of its delivery if, after examination of the Policy, the Policyholder is not satisfied with it for any reason. This Policy may be returned to the Company, at the address shown above. The Policy shall be null and void from the beginning and no benefits will be payable under its terms. However, if benefits are paid for claims incurred by the Policyholder during this period, there shall be no full refund of the premium that was paid by the Policyholder.

THE POLICY IS CONDITIONALLY RENEWABLE AT THE OPTION OF THE COMPANY: The Policy is renewable at the option of the Company on the anniversary date as long as the full premium is paid when due unless one of the reasons detailed under the Conditions of the Policy section occurs. If any one of such reasons occurs, the Company reserves the right to not renew or to terminate the Policy. Premiums are those currently in use on each renewal date of the Policy.

NOTICE TO BUYER: this Policy is non-participating and provides Vision benefits only. This coverage provided is intended to only supplement other policyholder's coverage's. It does not pay benefits for any other type of loss. When you enroll in this product and if you have vision coverage under another medical plan, you may have duplicate coverage for these benefits, and the two benefit plans will not coordinate with each other.

AGREEMENT AND CONSIDERATION: This is to certify that, in consideration of payment of all Premiums when due and receipt of an accurate and complete application information, the Company will insure the Policyholder for Vision benefits in accordance with the terms and conditions of this Policy. Coverage will begin at 12:01 AM on the Effective Date. It will remain in force until the first Renewal Date, and for such further periods for which it is renewed. All of the provisions within the following pages are a part of this Policy.

Brian Lobley
President and SVP
Commercial and Consumer Markets

Paula Sunshine
SVP and
Chief Marketing Executive

QCC INSURANCE COMPANY
Individual Adult Vision Benefits

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QCC INSURANCE COMPANY
Individual Adult Vision Benefits

DEFINITIONS

APPLICANT the person who applies for coverage under this Policy and with whom the Company has agreed to provide this coverage.

APPLICATION the written request of the Applicant for coverage under this Policy together with any amendments or modifications thereto.

BENEFIT PERIOD the specified period of time as shown in the ***Schedule of Benefits*** of this Policy during which charges for Covered Services must be Incurred in order to be eligible for payment by the Company. 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 section entitled ***Schedule of Benefits*** of this Policy, for which the Covered Person is responsible.

COPAYMENT is the amount the Policyholder is required to pay to the Provider prior to a vision examination or toward the cost of materials. The Copayments will be shown in the Schedule of Benefits.

COVERED PERSON an enrolled Applicant (Policyholder) or the Applicant's eligible Dependents who are enrolled under this Policy and for whom the required premium is being paid. See the definition of Policyholder.

COVERED SERVICES means a service or supply specified in this Policy for which benefits will be provided when rendered by a Provider.

DEPENDENT a Covered Person other than the Applicant as specified on the ***Application.***

EFFECTIVE DATE according to the Policy Provisions, the date on which coverage for a Covered Person begins under this Policy as shown on the records of the Company.

EYE EXAMINATION is a comprehensive examination and evaluation of the eyes performed by a physician, Ophthalmologist or Optometrist, which is included in the Schedule of Benefits section.

IDENTIFICATION CARD the currently effective card, issued to each Covered Person by the Company, for the current effective date of coverage which should be presented when a Covered Service is requested.

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.

MAXIMUM - the greatest amount payable by the Company set forth in the ***Schedule of Benefits***, for Covered Services.

NON-PARTICIPATING PROVIDER a Provider that does not participate in the Company's plan and is not required to accept the Company'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 Examinations and Refractive Services.

PARTICIPATING PROVIDER is a Provider who has entered into a contract with the Company to provide vision services and/or materials on a scheduled fee basis.

POLICY means this Policy, together with the Outline of Coverage, Premium Rate Letter, any endorsements there to or required notice issued by the Company, the Application and any supplemental applications approved by the Company, and the Covered Person's current identification card.

POLICYHOLDER is the individual (Covered Person) who has purchased this vision plan for him/herself.

PROVIDER is a practitioner who is legally qualified to provide vision services within the scope of their license. This term includes a Provider who is recognized as such in accordance with the laws of the State in which the services are provided. The Policy recognizes one category of Providers: **Participating Provider**.

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:

A. 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; or

B. For services rendered by a Non-Participating Provider, "Provider's Reasonable Charge" means the Reasonable and Customary Charges, or Benefit Maximums amount, or Billed Charge, whichever is less.

REASONABLE AND CUSTOMARY means the amount that is the usual or customary charge for the service or supply as determined by the Company. The chosen standard is an amount which is most often charged by other providers for similar services or supplies within the same geographic area where the service or supply is provided and who have training, experience and professional standing comparable to those of the actual provider of the service or supply. If no comparison exists, the Company determines what is reasonable by the severity and/or complexity of the Covered Person's condition for which the service or supply is provided.

RENEWAL DATE is the date the Policy will renew.

SCHEDULE OF BENEFITS summary of the Covered Services, payments, benefit Waiting Periods, maximums that are to be paid to or by the Covered Person, which are applicable to benefits payable under this Policy.

SPOUSE – The Policyholder's partner by marriage or by any union between two adults that is recognized by law in the Commonwealth of Pennsylvania.

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

TERMINATION DATE is the date on which the benefit for the Policyholder shown on this Policy expires, at 12:00am of the day immediately following the termination date, the Policy will no longer be effective.

WAITING PERIOD(s) A period of time a Covered Person must be enrolled under the Policy before benefits will be paid for certain Covered Services as shown on the attached Schedule of Benefits.

QCC INSURANCE COMPANY
Individual Adult Vision Benefits

CONDITIONS OF THE POLICY

ELIGIBILITY

The Covered Person that will be eligible for benefits under this Policy will be the individual Policyholder that has completed the Application for coverage and eligible Dependents as specified to the Company as eligible for coverage.

Eligible Dependent
Eligible Dependent is defined as:

1. The Covered Person's Spouse under a legally valid existing marriage.

2. The unmarried children, between the ages of nineteen (19) and twenty-six (26), including step-children, children legally placed for adoption, and legally adopted children of the Covered Person's Spouse, or children who continue to be incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Policyholder for maintenance and support, or children for whom the Covered Person is a legal guardian of dependent children covered under the Policy.

GEOGRAPHIC SERVICE AREA

The Covered Person must continue to reside in the geographic area served by the Company. Should the Covered Person change his or her residence to a geographic area outside the area served by the Company, or are absent from the area for more than 6 consecutive months, the Covered Person will no longer be eligible for benefits under this policy.

POLICY PREMIUM RATE AND REVISION

The Policy premium rate that applies to this Policy at any given time are those on file with and approved by the Pennsylvania Insurance Department. The rates are based as a Table of Rates, which the Company has the right to revise, but can only change these premium rates if we raise the premium rates for all policies like your Policy. The Company will make no changes to your premium rate because of claims made under this Policy. The Company, subject to the approval of the Insurance Department of the Commonwealth of Pennsylvania may alter or revise this Policy by endorsement or notice of change issued by the Company and modifies the applicable Policy premium rates. The premium rates may be changed as of the Policy anniversary date, provided that written notice of such a rate change shall be given by the Company not later than (30) days prior to any change in premium at renewal.

POLICY TERM AND RENEWAL

The Term of this Policy is for one year beginning at 12:01 AM on the Effective Date shown on the Premium Rate Letter. This Policy will renew at the option of the Company on the anniversary date from year to year if the full premium is paid on a monthly basis as shown on the Premium Rate Letter. We will provide at least a 30 day advance notice of any change in Premium. The Policyholder may elect to renew the Policy on their Renewal Date. The Policyholder may also change their Vision benefit plan at renewal by notifying the Company. If a change of benefit is made, the Company will supply the Policyholder with an updated Policy which will depict the product choice you have selected. Any change in premium will be included

in your next bill. There will be no evidence of insurability that will be required to change a Vision benefit at renewal.

If you elect to not renew, you will not be permitted to apply for a new Vision policy with the Company for one year from your renewal date.

No benefit will be paid for expenses incurred during any period for time for which the premium has not been paid, subject to the Grace Period.

GRACE PERIOD

This Policy has a grace period of 31 days. This means that if a payment is not made on or before the date it is due, it may be paid during the grace period. During the grace period, the Coverage will stay in force. If the appropriate payment is not received at the end of the thirty-one (31) day period, this Policy automatically terminates.

REINSTATEMENT

If any Premium is not paid within the Grace Period specified above, a subsequent acceptance of Premium by the Company or by any agent duly authorized by the Company to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. However, if the Company requires an application for reinstatement and issues a conditional receipt for the Premium, the Policy will be reinstated upon approval of such application by the Company. Lacking such approval, the Policy will be reinstated upon the forty-fifth (45th) day following the date of such conditional receipt unless the Company has previously notified the Policyholder in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. The Policyholder and Company shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

POLICY TERMINATION

1. The Company will not cancel or non-renew this Policy solely on the ground of health status of the Policyholder.

2. The Company will terminate this Policy if the premium is not received by the end of the grace period. The effective date of the termination shall be the day following the conclusion of the Grace Period. You will not be able to apply for a new Vision Policy for one year from the termination effective date.

3. You the Policyholder may only terminate the Policy by sending a written notice to the Company. The termination will be effective on the first day of the month following the date requested in the Policyholder's written notification, unless premium is owed. If a premium is owed, the Policy termination will be effective subject to the Grace Period provision. You will not be able to apply for a new Vision Policy for one year from the termination effective date.

4. The Company shall terminate this Policy if the Policyholder obtained or attempted to obtain benefits or payment for benefits through deliberate or willful material misrepresentation. If benefits were provided though deliberate or willful material misrepresentation, the Policyholder agrees to reimburse the Company for such benefits.

5. The Company shall terminate this Policy if the Covered Person no longer resides in the Geographic Service Area, or are absent from the area for more than 6 consecutive months.

Benefits After Coverage Termination: The Company is not liable to pay any benefits for services which are started after the Termination Date of the Policyholder's coverage of their Policy.

QCC INSURANCE COMPANY
Individual Adult Vision Benefits

POLICY PROVISIONS

ENTIRE CONTRACT

The entire contract between the Company and the Policyholder consists of the Application, the Premium Rate Letter, the Policy, the Schedule of Benefits, any amendments, riders, or endorsements issued by the Company, the Policyholder Identification Card and the applicable Policyholder rate. No change in this Policy will be effective until approved by an authorized officer of the Company, along with the approval by the Pennsylvania Insurance Department. This approval must be noted on, or attached to this Policy. No agent or representative of this Company, other than an officer of the Company may otherwise change this Policy or waive any of its provisions.

EFFECTIVE DATE

The date on which the Policyholder benefits begin under this Policy as shown on the Policy records of the Company and as sent to you on our Premium Rate Letter. The Identification Card identifies the Policyholder as the Covered Person on this Policy.

VOIDANCE OF COVERAGE DUE TO MATERIAL MISREPRESENTATIONS

In the even a Policyholder makes a material misrepresentation or a false statement in obtaining coverage under this Policy, this Policy is void. If benefits were provided under a Policy issued under such circumstances, the Policyholder agrees to reimburse the Company for benefits which were provided.

QCC INSURANCE COMPANY
Individual Adult Vision Benefits

BENEFITS

PRE-EXISTING CONDITION

There will be no Pre-Existing Condition that will apply to this Policy. The Covered Services as shown in this Policy will apply as of the effective date of this coverage.

WHEN TO USE A NETWORK PROVIDER

This policy allows you to utilize your vision benefits through a provider who participates in the Company's network of Participating Providers. To find a Participating Provider, visit our website at (www.ibx.com/providersearch) or call the toll-free Customer Service number shown on the back of your ID card.

The vision benefit is administered by Davis Vision. The Policy will also provide vision benefits if you choose to use a Non-Participating Provider.

SCHEDULE OF BENEFITS

Subject to the exclusions, conditions, Waiting Periods and limitations set forth in this Policy, a Covered Person is entitled to the benefits within the benefit section for Covered Services by a Provider or supplier, unless otherwise indicated in the amounts specified in the **Schedule of Benefits.**
The Covered Services are subject to those provisions that are listed along with the limitations and exclusions as shown within this Policy.

The Schedule of Benefits will show:

- The Vision services that are covered;
- Any Waiting Period applicable to the Policy;
- Any percentage or dollar amount that will be paid by the Policy;
- The Copayment amount the Covered Person will need to pay for a Covered Service or any allowance toward a benefit;
- Time limitations, such as once every calendar year.

Vision Schedule of Benefits

VISION CARE - 100

Benefit Period	Once every calendar year.
Waiting Period	There is a 30 day Waiting Period applicable to all Covered Services and Supplies.
Coinsurance	None
Benefit Period Maximum (Participating)	$100 for all Covered Services and Supplies; except eye examination services are not included in this Benefit Period Maximum.

SCHEDULE OF COVERED SERVICES

COVERED SERVICES	AMOUNTS PAYABLE AND LIMITATIONS ON COVERED SERVICES	
	Participating*	**Non-Participating**
Eye exam, inclusive of dilation, as professionally indicated.	100% of the Provider's Reasonable Charge.	100% of the Provider's Reasonable Charge, up to a Maximum of $40.
Eyeglasses, including Spectacle Lenses and Frames (one pair).		
Spectacle Lenses		
• All ranges of prescriptions, oversize lenses, plastic lenses, single vision, lined bifocal, lined trifocal or lenticular lenses	100%	100%, up to a Maximum of: $40 – single vision $60 – bifocal/progressive $80 – trifocal $100 – lenticular
• Polycarbonate lenses for dependent children, monocular patients and patients with prescriptions greater than or equal to +/- 6.00 diopters	100%	
• Scratch resistant coating	100%	
• Ultraviolet (UV) coating	100%	

Frames		100%, up to a Maximum of $50
- Plan supplied:	100%, with a Copayment of:	
• Fashion selection	$0	
• Designer selection	$15	
• Premier selection	$40	
OR		
- Doctor supplied:	100%, up to a Maximum of $100 towards purchase and a 20% discount off balance over the $100 Maximum, not available at all Participating Providers.	
Elective Contact Lenses (in lieu of eyeglasses) including Standard, Specialty and Disposable Lenses	100%, up to a Maximum of $100 towards purchase and a 15% discount off balance over the $100 Maximum, not available at all Participating Providers.	100%, up to a Maximum of $80
Elective Contact Lenses Fitting and Follow-up Care	15% discount, not available at all Participating Providers.	Not Covered
Medically Necessary Contact Lenses (in lieu of eyeglasses or elective contact lenses) including Standard, Specialty and Disposable Lenses (with prior approval)	100%	100%, up to a Maximum of $225

* The Company reserves the right to modify the ***Schedule of Covered Services*** from time to time.

COVERED SERVICES

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

This plan 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 spectacle lenses or contact lenses, from a Participating Provider/Supplier, you may have no out-of-pocket costs, depending on your choice of hardware. The policy 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 policy 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.

A. **Eye Examination Services**

Such services, performed by a Professional Provider, as defined in the section entitled ***Definitions*** 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 Services as described in the Eye Examination Services subsection shown 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

A. 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 may provide benefits providing the Covered Person qualifies for such benefits. See the ***Schedule of Benefits*** for the benefit allowance, if any.

B. Payment for frames, or spectacle lenses and/or contact lenses will be made only if prescribed by a Professional Provider or Supplier.

QCC INSURANCE COMPANY
Individual Adult Vision Benefits

EXCLUSIONS

Except as specifically provided for in the Policy, 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 spectacle 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, regardless of whether they are prescribed, VDT eyeglasses, safety eyeglasses and safety goggles;
- For medical attention or surgical treatment of the eye;
- For diagnostic services, such as diagnosis 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 and ordered prior to such termination and delivered within thirty (30) days from such date;

- 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;

- Paid or payable by Medicare when Medicare is primary. For purposes of this Plan, a service, supply or charge is "payable under Medicare" when the Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;

- For eyeglass frames and contact lenses dispensed within the same Benefit Period by a Participating Provider;

- Other than specifically provided in the section entitled ***Vision Care Benefits*** of this Policy.

QCC INSURANCE COMPANY
Individual Adult Vision Benefits

CLAIMS PROVISIONS

IDENTIFICATION CARD
The Identification Card issued by the Company must be presented by the Covered Person to anyone furnishing the Covered Person with services or supplies.

PROOF OF LOSS
In the case of a claim for any loss, written proof of such loss must be furnished to the Company, within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

NOTICE OF CLAIM
Written notice of claim for treatment of illness or injury must be given to the Company within 20 days after the date when such treatment occurred. Failure to furnish within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. The notice that is given by the Covered Person shall be sent to the Company at 1901 Market Street, Philadelphia, PA 19103-1480. It can also be given to any authorized agent of the Company, with information sufficient to identify the Covered Person. This shall be deemed notice to this company.

CLAIM FORMS
The Company upon receipt of a notice of claim, will furnish to the Covered Person such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the Covered Person shall be deemed to have complied with the requirements of this Policy as to proof of loss.

TIME OF PAYMENT OF CLAIMS
Benefits for any loss covered by this Policy will be paid as soon as Company receives the proper written proof of such loss.

PAYMENT OF CLAIM
Indemnity for loss of life will be payable to the Provider, the Covered Person, or in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Covered Person. Any other accrued indemnities unpaid at the Covered Person's death may, at the option of the Covered Person, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Covered Person.

PHYSICAL EXAMINATIONS
The Company at its own expense shall have the right and opportunity to examine the Covered Person when and as often as it may reasonably require during the pendency of a claim hereunder.

QCC INSURANCE COMPANY
Individual Adult Vision Benefits
GENERAL PROVISIONS

RELEASE OF INFORMATION

The Covered Person agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this coverage may furnish to the Company, upon its request, any information (including copies of records relating to the illness or injury).

The Company may furnish similar information to other entities providing similar benefits at their request.

The Company shall provide to the Covered Person, upon their request, certain information regarding claims and charges submitted to the Company.

The Company may also furnish membership and/or coverage information to affiliated plans or other entities for the purpose of claims processing or facilitating patient care.

When the Company 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 Company 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.

TIME LIMITS ON CERTAIN DEFENSES

After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements made by the Covered Person in the application for such Policy shall be used to void the Policy or deny a claim for loss incurred or disability (as defined in the Policy) commencing after the expiration of such three year period.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty 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.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which the Covered Person resides on such date, is hereby amended to conform to the minimum requirements of such statutes.

COVERED PERSON/PROVIDER RELATIONSHIP

The choice of a Provider is solely yours.

The Company does not furnish Covered Services but only makes payment for Covered Services received by the Covered Person. The Company is not liable for any act or omission of any Provider. The Company has no responsibility for a Provider's failure or refusal to render Covered Services to a Covered Person.

MISSTATEMENT OF AGE

If the age of the Covered Person has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

NOTICE REGARDING NONDISCRIMINATION

The Covered Person has the right to receive health care services without discrimination:

- based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including sex stereotypes and gender identity;

- for medically necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;

- based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available; and

- related to gender transition if such denial or limitation results in discriminating against a transgender individual.

QCC INSURANCE COMPANY
Individual Adult Vision Benefits

RESOLVING PROBLEMS (COMPLAINTS/APPEALS)

Complaint Process

The Company has a process for Covered Persons to express complaints. To register a complaint, Covered Persons should call the Member Services Department at the telephone number on the back of the Identification Card or write to the Company at the following address:

QCC Insurance Company
General Correspondence
1901 Market Street
Philadelphia, PA 19103

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

Appeal Process

Filing an Appeal. The Company maintains procedures for the resolution of Covered Person Appeals. Internal Appeals may be filed within one hundred eighty (180) days of the receipt of a decision from the Company stating an adverse benefit determination. An Appeal occurs when the Covered Person or, after obtaining the Covered Person's authorization, either the Provider or another authorized representative requests a change of a previous decision made by the Company by following the procedures described here. (In order to authorize someone else to be the Covered Person's representative for the Appeal, the Covered Person must complete a valid authorization form. The Covered Person should contact the Company as directed below to obtain a "Member/Enrollee Authorization to Appeal by Provider or Other Representative" form or for questions regarding the requirements for an authorized representative.)

The Covered Person or other authorized person on behalf of the Covered Person, may request an Appeal by calling or writing to the Company, as defined in the letter notifying the Covered Person of the decision or as follows:

Member Appeals Department	Toll Free Phone: 1-888-671-5276 (TTY: 711)
P.O. Box 41820	Toll Free Fax: 1-888-671-5274 or
Philadelphia, PA, 19101-1820	Phila. Fax: 215-988-6558

Information for the Appeal Review;

The Covered Person or designee is entitled to a full and fair review. Specifically, at all appeal levels the Covered Person or designee may submit additional information pertaining to the case, to the Company. The Covered Person or designee may specify the remedy or corrective action being sought. At the Covered Person's request, the Company will provide access to and copies of all relevant documents, records, and other information that are not confidential, proprietary, or privileged. The Company will automatically provide the Covered Person or designee with any new or additional evidence considered, relied upon, or generated by the plan in connection with the appeal, which is used to formulate the rationale. Such evidence is provided as soon as

possible and in advance of the date the adverse notification is issued. This information is provided to the Covered Person or designee at no charge.

The Company will not terminate or reduce an-ongoing course of treatment without providing the Covered Person or designee with advance notice and the opportunity for advanced review.

Individuals with urgent care conditions or who are receiving an on-going course of treatment may proceed with an expedited external review at the same time as the internal expedited appeals process.

If the appeal is upheld, the letter states the reason(s) for the decision. If a benefit provision, internal, rule, guideline, protocol, or other similar criterion is used in making the determination, the Covered Person may request copies of this information at no charge. If the decision is to uphold the denial, there is an explanation of the scientific or clinical judgment for the determination. The letter also indicates the qualifications of the individual who decided the appeal and their understanding of the nature of the appeal. The Covered Person or designee may request in writing, at no charge, the name of the individual who participated in the decision to uphold the denial.

Changes in Covered Persons Appeals Processes. Please note that the Covered Persons Appeal processes described here may change at any time due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve or facilitate the Covered Persons Appeals processes, or to reflect other decisions regarding the administration of Covered Persons Appeal processes for this Contract.

Types of Appeals - Following are the two types of Appeals and the issues they address:

Medical Necessity Appeal – An Appeal by or on behalf of a Covered Person that focuses on issues of Medical Necessity and requests the Company 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. A Company Medical Director, who has had no previous involvement with the case and is not a subordinate of anyone involved with a previous adverse determination, is the decision maker for a Medical Necessity Internal Appeal. Either the Company's Medical Director or a consultant functions as a matched specialist. A matched specialist or "same or similar specialty Physician" is a licensed physician, psychologist or other health care professional who: is in the same or similar specialty that typically manages the care under review; (The Company Medical Director must also hold an active, unrestricted license.

Administrative Appeal – An Appeal by or on behalf of a Covered Person that focuses on unresolved disputes or objections regarding a Company 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, these are not the primary issues that affect the outcome of the Appeal. An employee of the Company is the decision maker for an Administrative Appeal. This individual has had no previous involvement with the case and is not a subordinate of anyone involved with a previous adverse determination.

Standard Internal Appeal:

Pre-service Appeal - An Appeal for benefits that, under the terms of this Contract, 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. For a standard Pre-Service appeal, a maximum of thirty (30) days is available for the one level of internal appeal.

Post-service Appeal - An Appeal for benefits that is not a Pre-service Appeal. (Post-service Appeals concerning claims for services that the Covered Person has already obtained do not qualify for review as Expedited/Urgent appeals.) For a standard Post-Service appeal, a maximum of sixty (60) days is available for the one level of internal appeal.

The decision of the Company is sent to the Covered Person or designee in writing within the timeframe noted above.

Expedited/Urgent Internal Appeal

Expedited/Urgent Appeal – An urgent expedited appeal is any appeal for medical care or treatment with respect to which the application of the time periods for making non-urgent determinations could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

The appeals review process for an urgent/expedited appeal mirrors the process described above under the section entitled "Types of Appeal".

The expedited review is completed promptly based on the Covered Person's health condition, but no later than seventy-two (72) hours after receipt of the expedited appeal request by the Company. Within seventy-two (72) hours after receipt of the expedited appeal, the Company notifies the Covered Person or designee by telephone of the determination. The determination is sent in writing within seventy-two hours (72) after the Covered Person or designee has received the verbal notification.

For urgent care appeals, the Covered Person or designee may also file an expedited external medical judgment review at the same time as filing an internal expedited medical necessity appeal.

If not satisfied with the standard or expedited decision from the Company, the Covered Person or designee has the right to initiate an external review as described below.

EXTERNAL REVIEWS – issues involving medical judgment or a rescission of coverage (except for non-payment of premiums) are coordinated by the Company in full compliance with the Federally administered private accredited Independent Review Organization (IRO) process as required by Health Care Reform.

Standard External Review Process

The Member/Designee may request a Standard External Review of a grievance/rescission of coverage by calling or writing to the Plan within one hundred and twenty (120) calendar days of receipt of the Internal Appeal decision letter. The Member is not required to pay any of the costs associated with the external review.

The Member/Designee is sent written confirmation of receipt of his/her External Review request from the Plan within five (5) business days of receipt of the request. This confirmation includes the name and contact information for the Plan staff person assigned to facilitate the processing of the Member's External Review and information on the IRO assignment. Information on the IRO assignment identifies the assigned IRO by name and states the qualifications of the individual who reviews the appeal.

Whenever possible, the IRO assigned to the External Review request, is a different organization than the one that supplied the same/or similar specialty review for the internal Appeal process. The individual appointed by the IRO to review the Member's External Review, has not been previously involved in any aspect of decision-making on the appeal, nor are they a subordinate of any previous decision-maker.

The IRO has no direct or indirect professional, familial or financial conflicts of interest with the Plan, with the Member, or the Designee. The Plan's arrangements for assignment of an IRO and payment for the services of an IRO do not constitute a conflict of interest. When a conflict of interest is raised or another material objection is recognized, the Plan assigns a new IRO and/or requires the assigned IRO to appoint a new reviewer. This reviewer is not the same person who served as a matched specialist for the internal appeal process, nor a subordinate of that person. If the Member/Designee feels that a conflict exists, he/she should call or write the contact person listed on the acknowledgement letter from the Plan no later than two (2) business days from receipt of the acknowledgment letter from the Plan.

The Plan sends the Member/Designee and the IRO, a letter listing all documents forwarded to the IRO. These documents include copies of all information submitted for the Internal Appeal process, as well as any additional information that the Member/Designee or the Plan may submit. If the Member wishes to submit additional information for consideration by the IRO, he should do so within ten (10) calendar days of the Member's request for an External Review.

The Plan does not interfere with the IRO's proceedings or appeals decisions. The IRO conducts a thorough review in which it considers all previously determined facts, allows the introduction of new information considers and assesses sound medical evidence, and makes a decision that is not bound by the decisions or conclusions of the Internal Appeal process.

The IRO makes its final decision within forty-five (45) calendar days of receipt of the Member's request by the Plan and simultaneously issues its decision in writing to the Member or Designee and to the Plan. The established deadline for a decision from the IRO may only be exceeded for good cause when a reasonable delay for a specific period is acceptable to the Member or Designee. If the decision of the IRO is that the services are covered, the Plan authorizes the service and/or pays the claims. The Member/Designee is notified in writing of the time frame and procedure for claim payment or approval of the service in the event of an overturn of the Plan's earlier determination. The Plan implements the IRO's decision within the time period, if any, specified by the IRO.

The external decision is binding on the Plan.

Urgent Expedited External Review Process

The Member/Designee may request an Urgent External /Medical Judgment Review or a rescission of coverage review for urgent/expedited situations through an IRO. The Member or Designee is not required to pay any of the costs associated with the External Review.

With the exception of time frames, the Urgent/Expedited External Review mirrors the process described above under the External Standard Review.

Within twenty-four (24) hours of receipt of the Member's request for an Urgent/Expedited Review, the Plan confirms the request and faxes the request to the assigned IRO. During this time, the Plan also forwards to the IRO, by secure electronic transmission or overnight delivery, all information submitted in the Internal Appeal Process and any additional information that the Member, Designee, or the Plan wishes to submit to the IRO.

The IRO makes a decision and simultaneously notifies the Member/Designee and the Plan in writing within seventy-two (72) hours of receipt of all relevant documentation. The decision letter identifies the assigned IRO by name and states the qualifications of the individual that the IRO appoints to review the External Review.

If the decision of the IRO is that the services are eligible, the Plan authorizes the service and/or pays the claims. The Member is notified in writing of the time frame and procedure for claim payment and/or approval of the service in the event of an overturn of the plan's earlier determination. The Plan implements the IRO's decision within the time period, if any, specified by the IRO.

The external decision is binding on the Plan.

If your health plan is subject to the requirements of the Employee Retirement Income Security Act (ERISA), following your appeal you may have the right to bring civil action under Section 502(a) of the Act.

For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (TTY: 711). Additionally, a consumer assistance program may be able to assist you at:

Pennsylvania Department of Insurance
1325 Strawberry Square
Harrisburg, PA 17111

1-877-881-6388 (TTY: 711)
www.insurance.pa.gov

If your Company fails to “strictly adhere” to the internal appeals process, you may initiate an external review or file appropriate legal action under state law or ERISA unless:

- Violation was *de minimis* (minimal).
- Did not cause (or likely to cause) prejudice or harm to the claimant.
- Was for good cause or due to matters beyond the control of the insurer/plan.
- In the context of a good faith exchange of information with the claimant.
- Not part of a pattern or practice of violations.

THE POLICY IS CONDITIONALLY RENEWABLE AT THE OPTION OF THE COMPANY: The Policy is renewable at the option of the Company on the anniversary date as long as the full premium is paid when due unless one of the reasons detailed under the Conditions of the Policy section occurs. If any one of such reasons occurs, the Company reserves the right to not renew or to terminate the Policy. Premiums are those currently in use on each renewal date of the Policy.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníltí'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih koji' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں. کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan 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 the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.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, DC 20201, 1-800- 368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

REQUIRED OUTLINE OF COVERAGE
FOR
INDIVIDUAL SUPPLEMENTAL INSURANCE COVERAGE
ADULT VISION BENEFITS

Issued by

QCC Insurance Company*
(Called the Company)

***a subsidiary of Independence Blue Cross – an independent licensee of the Blue Cross and Blue Shield Association**

A Pennsylvania Corporation
Located at:
1901 Market Street
Philadelphia, PA 19103

NOTICE OF RIGHT TO EXAMINE POLICY: The Policyholder may return this Policy within (10) days of its delivery if, after examination of the Policy, the Policyholder is not satisfied with it for any reason. This Policy may be returned to the Company, to the address shown above. The Policy shall be null and void from the beginning and no benefits will be payable under its terms. However, if benefits are paid for claims incurred by the Policyholder during this period, there shall be no full refund of the premium that was paid by the Policyholder.

When you enroll in this product and have vision coverage under another medical plan, you may have duplicate coverage for these benefits and that the two benefit plans will not coordinate with each other.

OUTLINE OF COVERAGE

1. **Read your Policy Carefully –** This outline of coverage provides a very brief description of important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is therefore, important that you READ YOUR POLICY CAREFULLY!

2. **Supplemental Insurance Coverage –** Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

THIS IS A NON-PARTICIPATING CONTRACT

3. **A brief specific description of the benefits, including dollar amounts contained in this Policy:**

Subject to the Exclusions, conditions, Waiting Periods and limitations set forth in this Policy, a Covered Person is entitled to the benefits within the benefit section for Covered Services by a Provider or supplier, unless otherwise indicated in the amounts specified in the **Schedule of Benefits.**

WHEN TO USE A NETWORK PROVIDER

This policy allows you to utilize your vision benefits through a provider who participates in the Company's network of Participating Providers. To find a Participating Provider, visit our website at (www.ibx.com/providersearch) or call the toll-free number shown on the back of your ID card.

The vision benefit is administered by Davis Vision. The Policy will also provide vision benefits if you choose to use a Non-Participating Provider.

Schedule of Benefits

The Covered Services are subject to those provisions that are listed along with the limitations and exclusions as shown within this Policy.

The Schedule of Benefits will show:

- The Vision services that are covered;
- Any Waiting Period applicable to the Policy;
- Any percentage or dollar amount that will be paid by the Policy;
- The Copayment amount the Covered Person will need to pay for a Covered Services or any allowance toward a benefit;
- Time limitations, such as once every calendar year.

Vision Schedule of Benefits

VISION CARE - 100

Benefit Period	Once every calendar year.
Waiting Period	There is a 30 day Waiting Period applicable to all Covered Services and Supplies.
Coinsurance	None
Benefit Period Maximum (Participating)	$100 for all Covered Services and Supplies; except eye examination services are not included in this Benefit Period Maximum.

SCHEDULE OF COVERED SERVICES

COVERED SERVICES	AMOUNTS PAYABLE AND LIMITATIONS ON COVERED SERVICES	
	Participating*	**Non-Participating**
Eye exam, inclusive of dilation, as professionally indicated.	100% of the Provider's Reasonable Charge.	100% of the Provider's Reasonable Charge, up to a Maximum of $40.
Eyeglasses, including Spectacle Lenses and Frames (one pair).		
Spectacle Lenses		
• All ranges of prescriptions, oversize lenses, plastic lenses, single vision, lined bifocal, lined trifocal or lenticular lenses	100%	100%, up to a Maximum of: $40 – single vision $60 – bifocal/progressive $80 – trifocal $100 – lenticular
• Polycarbonate lenses for dependent children, monocular patients and patients with prescriptions greater than or equal to +/- 6.00 diopters	100%	
• Scratch resistant coating	100%	
• Ultraviolet (UV) coating	100%	

Frames		100%, up to a Maximum of $50
- Plan supplied:	100%, with a Copayment of:	
• Fashion selection	$0	
• Designer selection	$15	
• Premier selection	$40	
OR		
- Doctor supplied:	100%, up to a Maximum of $100 towards purchase and a 20% discount off balance over the $100 Maximum, not available at all Participating Providers.	
Elective Contact Lenses (in lieu of eyeglasses) including Standard, Specialty and Disposable Lenses	100%, up to a Maximum of $100 towards purchase and a 15% discount off balance over the $100 Maximum, not available at all Participating Providers.	100%, up to a Maximum of $80
Elective Contact Lenses Fitting and Follow-up Care	15% discount, not available at all Participating Providers.	Not Covered
Medically Necessary Contact Lenses (in lieu of eyeglasses or elective contact lenses) including Standard, Specialty and Disposable Lenses (with prior approval)	100%	100%, up to a Maximum of $225

* The Company reserves the right to modify the ***Schedule of Covered Services*** from time to time.

COVERED SERVICES

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

This plan 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 spectacle lenses or contact lenses, from a Participating Provider/Supplier, you may have no out-of-pocket costs, depending on your choice of hardware. The policy 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 policy 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.

A. **Eye Examination Services**

Such services, performed by a Professional Provider, as defined in the section entitled ***Definitions*** 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 Services as described in the Eye Examination Services subsection shown 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

A. 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 may provide benefits providing the Covered Person qualifies for such benefits. See the ***Schedule of Benefits*** for the benefit allowance, if any.

B. Payment for frames, or spectacle lenses and/or contact lenses will be made only if prescribed by a Professional Provider or Supplier.

ELIGIBILITY

The Covered Person that will be eligible for benefits under this Policy will be the individual Policyholder that has completed the Application for coverage and eligible Dependents as specified to the Company as eligible for coverage.

Eligible Dependent

Eligible Dependent is defined as:

1. The Covered Person's Spouse under a legally valid existing marriage.

2. The unmarried children, between the ages of nineteen (19) and twenty-six (26), including step-children, children legally placed for adoption, and legally adopted children of the Covered Person's Spouse, or children who continue to be incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the Policyholder for maintenance and support, or children for whom the Covered Person is a legal guardian of dependent children covered under the Policy.

GEOGRAPHIC SERVICE AREA

The Covered Person must continue to reside in the geographic area served by the Company. Should the Covered Person change his or her residence to a geographic area outside the area served by the Company, or are absent from the area for more than 6 consecutive months, the Covered Person will no longer be eligible for benefits under this policy.

POLICY PREMIUM RATE AND REVISION

The Policy premium rate that applies to this Policy at any given time are those on file with and approved by the Pennsylvania Insurance Department. The rates are based as a Table of Rates, which the Company has the right to revise, but can only change these premium rates if we raise the premium rates for all policies like your Policy. The Company will make no changes to your premium rate because of claims made under this Policy. The Company, subject to the approval of the Insurance Department of the Commonwealth of Pennsylvania may alter or revise this Policy by endorsement or notice of change issued by the Company and modifies the applicable Policy premium rates. The premium rates may be changed as of the Policy anniversary date, provided that written notice of such a rate change shall be given by the Company not later than (30) days prior to any change in premium at renewal.

POLICY TERM AND RENEWAL

The Term of this Policy is for one year beginning at 12:01 AM on the Effective Date shown on the Premium Rate Letter. This Policy will renew at the option of the Company on the anniversary date from year to year if the full premium is paid on a monthly basis as shown on the Premium Rate Letter. We will provide at least a 30 day advance notice of any change in Premium. The Policyholder may elect to renew the Policy on their Renewal Date. The Policyholder may also change their Vision benefit plan at renewal by notifying the Company. If a change of benefit is made, the Company will supply the Policyholder with an updated Policy which will depict the product choice you have selected. Any change in premium will be included in your next bill. There will be no evidence of insurability that will be required to change a Vision benefit at renewal.

If you elect to not renew, you will not be permitted to apply for a new Vision policy with the Company for one year from your renewal date.

No benefit will be paid for expenses incurred during any period for time for which the premium has not been paid, subject to the Grace Period.

GRACE PERIOD

This Policy has a grace period of 31 days. This means that if a payment is not made on or before the date it is due, it may be paid during the grace period. During the grace period, the Coverage will stay in force. If the appropriate payment is not received at the end of the thirty-one (31) day period, this Policy automatically terminates.

REINSTATEMENT

If any Premium is not paid within the Grace Period specified above, a subsequent acceptance of Premium by the Company or by any agent duly authorized by the Company to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. However, if the Company requires an application for reinstatement and issues a conditional receipt for the Premium, the Policy will be reinstated upon approval of such application by the Company. Lacking such approval, the Policy will be reinstated upon the forty-fifth (45th) day following the date of such conditional receipt unless the Company has previously notified the Policyholder in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. The Policyholder and Company shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

POLICY TERMINATION

1. The Company will not cancel or non-renew this Policy solely on the ground of health status of the Policyholder.

2. The Company will terminate this Policy if the premium is not received by the end of the grace period. The effective date of the termination shall be the day following the conclusion of the Grace Period. You will not be able to apply for a new Vision Policy for one year from the termination effective date.

3. You the Policyholder may terminate the Policy by sending a written notice to the Company. The termination will be effective on the first day of the month following the date requested in the Policyholder's written notification, unless premium is owed. If a premium is owed, the Policy termination will be effective subject to the Grace Period provision. You will not be able to apply for a new Vision Policy for one year from the termination effective date.

4. The Company shall terminate this Policy if the Policyholder obtained or attempted to obtain benefits or payment for benefits through deliberate or willful material misrepresentation. If benefits were provided though deliberate or willful material misrepresentation, the Policyholder agrees to reimburse the Company for such benefits.

5. The Company shall terminate this Policy if the Covered Person no longer resides in the Geographic Service Area, or are absent from the area for more than 6 consecutive months.

Benefits After Coverage Termination: The Company is not liable to pay any benefits for services which are started after the Termination Date of the Policyholder's coverage of their Policy.

EXCLUSIONS

Except as specifically provided for in the Policy, 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 spectacle 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, regardless of whether they are prescribed, VDT eyeglasses, safety eyeglasses and safety goggles;
- For medical attention or surgical treatment of the eye;
- For diagnostic services, such as diagnosis 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 and ordered prior to such termination and delivered within thirty (30) days from such date;

- 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;

- Paid or payable by Medicare when Medicare is primary. For purposes of this Plan, a service, supply or charge is "payable under Medicare" when the Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;

- For eyeglass frames and contact lenses dispensed within the same Benefit Period by a Participating Provider;

- Other than specifically provided in the section entitled ***Vision Care Benefits*** of this Policy.

INDEPENDENCE BLUE CROSS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION[1]

PLEASE REVIEW IT CAREFULLY.

Independence Blue Cross[2] values you as a customer, and protection of your privacy is very important to us. In conducting our business, we will create and maintain records that contain protected health information about you and the health care provided to you as a member of our health plans.

Note: "Protected health information" or "PHI" is information about you, including information that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We protect your privacy by:

- limiting who may see your PHI;
- limiting how we may use or disclose your PHI;
- informing you of our legal duties with respect to your PHI;
- explaining our privacy policies; and
- adhering to the policies currently in effect.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members' protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We also are required by the federal Health Insurance Portability and Accountability Act (or "HIPAA") Privacy Rule to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

[1] If you are enrolled in a self-insured group benefit program, this Notice is not applicable. If you are enrolled in such a program, you should contact your Group Benefit Manager for information about your group's privacy practices. If you are enrolled in the Federal Employee Service Benefit Plan, you will receive a separate Notice.

[2] For purposes of this Notice, "Independence Blue Cross" refers to the following companies: Independence Blue Cross, Keystone Health Plan East, QCC Insurance Company, and Vista Health Plan, Inc. independent licensees of the Blue Cross and Blue Shield Association

This revised Notice took effect on July 18, 2017, and will remain in effect until we replace or modify it.

Copies of this Notice

You may request a copy of our Notice at any time. If you want more information about our privacy practices, or have questions or concerns, please contact Member Services by calling the telephone number on the back of your Member Identification Card, or contact us using the contact information at the end of this Notice.

Changes to this Notice

The terms of this Notice apply to all records that are created or retained by us which contain your PHI. We reserve the right to revise or amend the terms of this Notice. A revised or amended Notice will be effective for all of the PHI that we already have about you, as well as for any PHI we may create or receive in the future. We are required by law to comply with whatever Privacy Notice is currently in effect. You will be notified of any material change to our Privacy Notice before the change becomes effective. When necessary, a revised Notice will be mailed to the address that we have on record for the contract holder of your member contract, and will also be posted on our web site at www.ibx.com.

Potential Impact of State Law

The HIPAA Privacy Rule generally does not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

How We May Use and Disclose Your Protected Health Information (PHI)

In order to administer our health benefit programs effectively, we will collect, use and disclose PHI for certain of our activities, including payment of covered services and health care operations.

The following categories describe the different ways in which we may use and disclose your PHI. Please note that every permitted use or disclosure of your PHI is not listed below. However, the different ways we will, or might, use or disclose your PHI do fall within one of the permitted categories described below.

Treatment: We may disclose information to doctors, pharmacies, hospitals and other health care providers who take care of you to assist in your treatment or the coordination of your care.

Payment: We may use and disclose your PHI for all payment activities including, but not limited to, collecting premiums or to determine or fulfill our responsibility to provide health care coverage under our health plans. This may include coordinating benefits with other health care programs or insurance carriers, such as Medicare or Medicaid. For example, we may use and disclose your PHI to pay claims for services provided to you by doctors or hospitals which are covered by your health plan(s), or to determine if requested services are covered under your health plan. We may also use and disclose your PHI to conduct business with other Independence Blue Cross affiliate companies.

Health Care Operations: We may use and disclose your PHI to conduct and support our business and management activities as a health insurance issuer. For example, we may use and disclose your PHI to determine our premiums for your health plan, to conduct quality assessment and improvement activities, to conduct business planning activities, to conduct fraud detection programs, to conduct or arrange for medical review, or to engage in care coordination of health care services.

We may also use and disclose your PHI to offer you one of our value added programs like smoking cessation or discounted health related services, or to provide you with information about one of our disease management programs or other available Independence Blue Cross health products or health services.

We may also use and disclose your PHI to provide you with reminders to obtain preventive health services, and to inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.

Marketing: Your PHI will not be sold, used or disclosed for marketing purposes without your authorization except where permitted by law. Such exceptions may include: a marketing communication to you that is in the form of (a) a face-to-face communication, or (b) a promotional gift of nominal value.

Release of Information to Plan Sponsors: Plan sponsors are employers or other organizations that sponsor a group health plan. We may disclose PHI to the plan sponsor of your group health plan as follows:

- We may disclose "summary health information" to your plan sponsor to use to obtain premium bids for providing health insurance coverage or to modify, amend or terminate its group health plan. "Summary health information" is information that summarizes claims history, claims expenses, or types of claims experience for the individuals who participate in the plan sponsor's group health plan;
- We may disclose PHI to your plan sponsor to verify enrollment/disenrollment in your group health plan;
- We may disclose your PHI to the plan sponsor of your group health plan so that the plan sponsor can administer the group health plan; and
- If you are enrolled in a group health plan, your plan sponsor may have met certain requirements of the HIPAA Privacy Rule that will permit us to disclose PHI to the plan sponsor. Sometimes the plan sponsor of a group health plan is the employer. In those circumstances, we may disclose PHI to your employer. You should talk to your employer to find out how this information will be used.

Research: We may use or disclose your PHI for research purposes if certain conditions are met. Before we disclose your PHI for research purposes without your written permission, an Institutional Review Board (a board responsible under federal law for reviewing and approving research involving human subjects) or Privacy Board reviews the research proposal to ensure that the privacy of your PHI is protected, and to approve the research.

Required by Law: We may disclose your PHI when required to do so by applicable law. For example, the law requires us to disclose your PHI:

- When required by the Secretary of the U.S. Department of Health and Human Services to investigate our compliance efforts; and

- To health oversight agencies, to allow them to conduct Health Oversight Activities described below.

Public Health Activities: We may disclose your PHI to public health agencies for public health activities that are permitted or required by law, such as to:

- prevent or control disease, injury or disability;
- maintain vital records, such as births and deaths;
- report child abuse and neglect;
- notify a person about potential exposure to a communicable disease;
- notify a person about a potential risk for spreading or contracting a disease or condition;
- report reactions to drugs or problems with products or devices;
- notify individuals if a product or device they may be using has been recalled; and
- notify appropriate government agency(ies) and authority(ies) about the potential abuse or neglect of an adult patient, including domestic violence.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Health oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Lawsuits and Other Legal Disputes: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process once we have met all administrative requirements of the HIPAA Privacy Rule.

Law Enforcement: We may disclose your PHI to law enforcement officials under certain conditions. For example, we may disclose PHI:

- to permit identification and location of witnesses, victims, and fugitives;
- in response to a search warrant or court order;
- as necessary to report a crime on our premises;
- to report a death that we believe may be the result of criminal conduct; or
- in an emergency, to report a crime.

Coroners, Medical Examiners, or Funeral Directors: We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties.

Organ and Tissue Donation: We may use or disclose your PHI to organizations that handle organ and tissue donation and distribution, banking, or transplantation.

To Prevent a Serious Threat to Health or Safety: As permitted by law, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Military and National Security: We may disclose to military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials PHI required for lawful intelligence, counter-intelligence, and other national security activities.

Inmates: If you are a prison inmate, we may disclose your PHI to the prison or to a law enforcement official for: (1) the prison to provide health care to you; (2) your health and safety, and the health and safety of others; or (3) the safety and security of the prison.

Underwriting: We will not use genetic information about you for underwriting purposes.

Workers' Compensation: As part of your workers' compensation claim, we may have to disclose your PHI to a worker's compensation carrier.

To You: When you ask us to, we will disclose to you your PHI that is in a "designated record set." Generally, a designated record set contains medical, enrollment, claims and billing records we may have about you, as well as other records that we use to make decisions about your health care benefits. You can request the PHI from your designated record set as described in the section below called "Your Privacy Rights Concerning Your Protected Health Information."

To Your Personal Representative: If you tell us to, we will disclose your PHI to someone who is qualified to act as your personal representative according to any relevant state laws. In order for us to disclose your PHI to your personal representative, you must send us a completed Independence Blue Cross Personal Representative Designation Form and documentation that supports the person's qualification according to state law (such as a power of attorney or guardianship). To request the Independence Blue Cross Personal Representative Designation Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.ibx.com, or write us at the address at the end of this Notice. However, the HIPAA Privacy Rule permits us to choose not to treat that person as your personal representative when we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse or neglect by the person; (ii) treating the person as your personal representative could endanger you; or (iii) in our professional judgment, it is not in your best interest to treat the person as your personal representative.

To Family and Friends: Unless you object, we may disclose your PHI to a friend or family member who has been identified as being involved in your health care. We also may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your PHI, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

Parents as Personal Representatives of Minors: In most cases, we may disclose your minor child's PHI to you. However, we may be required to deny a parent's access to a minor's PHI according to applicable state law.

Health Information Exchanges

We share your health information electronically through certain Health Information Exchanges ("HIEs"). A HIE is a secure electronic data sharing network. In accordance with applicable federal and state privacy and security requirements, regional health care providers participate in HIEs to exchange patient information in real-time to help facilitate delivery of health care, avoid duplication of services, and more efficiently coordinate care. As a participant in HIEs, Independence shares your health information we may have received when a claim has been submitted for services you have received among authorized participating providers, such as physicians, hospitals, and health systems for the purpose of treatment, payment and health care operations as permitted by law.
During an emergency, patients and their families may forget critical portions of their medical history which may be very important to the treating physician who is trying to make a quick, accurate diagnosis in order to treat the sick patient. Independence, through its participation in an HIE, makes pertinent medical history, including diagnoses, studies, lab results, medications and the treating physicians we may receive on a claim available to participating emergency room physicians while the patient is receiving care. This is invaluable to the physician, expediting the diagnosis and proper treatment of the patient.

Your treating providers who participate with an HIE, and also submit health information with the HIE, will have the ability to access your health information through the HIE and send records to your treating physicians. Through direct requests to the HIE, we will receive various types of protected health information such as pharmacy or laboratory services, or information when you have been discharged from a hospital which may be used to coordinate your care, provide case management services, or otherwise reduce duplicative services and improve the overall quality of care to our members. All providers that participate in HIEs agree to comply with certain privacy and security standards relating to their use and disclosure of the health information available through the HIE.

As an Independence member, you have the right to opt-out which means your health information will not be accessible through the HIE. Through the regional HIE (www.hsxsepa.org/patient-options-opt-out-back) website or the State HIE (www.dhs.pa.gov/citizens/healthinformationexchange/) website consumers or providers can access an online, fax, or mail form permitting patients to remove themselves (opt-out) or reinstate themselves (opt back in) to the HIE. It will take approximately one business day to process an opt-out request. If you choose to opt-out of the HIE, your health care providers will not be able to access your information through the HIE. Even if you opt-out, this will not prevent your health information from being made available and released through other means (i.e. fax, secure email) to authorized individuals, such as network providers for paying claims, coordinating care, or administering your health benefits in accordance with the law and in the normal course of conducting our business as permitted under applicable law. For more information on HIEs, please go to www.hsxsepa.org/consumers-0 or to www.paehealth.org.

Right to Provide an Authorization for Other Uses and Disclosures

- Other uses and disclosures of your PHI that are not described above will be made only with your written authorization.
- You may give us written authorization permitting us to use your PHI or disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your PHI that are not identified by this Notice, or are not otherwise permitted by applicable law.

Any authorization that you provide to us regarding the use and disclosure of your PHI may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Of course, we are unable to take back any disclosures that we have already made with your authorization. We may also be required to disclose PHI as necessary for purposes of payment for services received by you prior to the date when you revoked your authorization.

Your authorization must be in writing and contain certain elements to be considered a valid authorization. For your convenience, you may use our approved Independence Blue Cross Authorization Form. To request the Independence Blue Cross Authorization Form, please contact Member Services at the telephone number listed on the back of your Member Identification card, print the form from our web site at www.ibx.com, or write us at the address at the end of this Notice.

Your Privacy Rights Concerning Your Protected Health Information (PHI)
You have the following rights regarding the PHI that we maintain about you. Requests to exercise your rights as listed below must be in writing. For your convenience, you may use our approved Independence Blue Cross form(s). To request a form, please contact Member Services at the telephone number listed on the back of your Member Identification card or write to us at the address listed at the end of this Notice.

Right to Access Your PHI: You have the right to inspect or get copies of your PHI contained in a designated record set. Generally, a “designated record set” contains medical, enrollment, claims and billing records we may have about you, as well as other records that we may use to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies of your PHI in a format other than photocopies such as by electronic means in certain situations. We will use the format you request unless we cannot practicably do so. We may charge a reasonable fee for copies of PHI (based on our costs), for postage, and for a custom summary or explanation of PHI. You will receive notification of any fee(s) to be charged before we release your PHI, and you will have the opportunity to modify your request in order to avoid and/or reduce the fee. In certain situations, we may deny your request for access to your PHI. If we do, we will tell you our reasons in writing, and explain your right to have the denial reviewed.

Right to Amend Your PHI: You have the right to request that we amend your PHI if you believe there is a mistake in your PHI, or that important information is missing. Approved amendments made to your PHI will also be sent to those who need to know, including (where appropriate) Independence Blue Cross's vendors (known as "Business Associates"). We may also deny your request if, for instance, we did not create the information you want amended. If we deny your request to amend your PHI, we will tell you our reasons in writing, and explain your right to file a written statement of disagreement.

Right to an Accounting of Certain Disclosures: You may request, in writing, that we tell you when we or our Business Associates have disclosed your PHI (an "Accounting"). Any accounting of disclosures will **not** include those we made:

- for payment, or health care operations;
- to you or individuals involved in your care;
- with your authorization;
- for national security purposes;
- to correctional institution personnel; or
- before April 14, 2003.

The first accounting in any 12-month period is without charge. We may charge you a reasonable fee (based on our cost) for each subsequent accounting request within a 12-month period. If a subsequent request is received, we will notify you of any fee to be charged, and we will give you an opportunity to withdraw or modify your request in order to avoid or reduce the fee.

Right to Request Restrictions: You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to your request. However, if we do agree, we will be bound by our agreement except when required by law, in emergencies, or when information is necessary to treat you. An approved restriction continues until you revoke it in writing, or until we tell you that we are terminating our agreement to a restriction.

Right to Request Confidential Communications: You have the right to request that we use alternate means or an alternative location to communicate with you in confidence about your PHI. For instance, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. Your written request must clearly state that the disclosure of all or part of your PHI at your current address or method of contact we have on record could be an endangerment to you. We will require that you provide a reasonable alternate address or other method of contact for the confidential communications. In assessing reasonableness, we will consider our ability to continue to receive payment and conduct health care operations effectively, and the subscriber's right to payment information. We may exclude certain communications that are commonly provided to all members from confidential communications. Examples of such communications include benefit booklets and newsletters.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of our Notice of Privacy Practices. You can request a copy at any time, even if you have agreed to receive this Notice electronically. To request a paper copy of this Notice, please contact Member Services at the telephone number on the back of your Member Identification Card.

Right to Notification of a Breach of Your PHI: You have the right to and will be notified following a breach of your unsecured PHI or if a security breach occurs involving your PHI.

Your Right to File a Privacy Complaint
If you believe your privacy rights have been violated, or if you are dissatisfied with Independence Blue Cross's privacy practices or procedures, you may file a complaint with the Independence Blue Cross Privacy Office and with the Secretary of the U.S. Department of Health and Human Services.

You will not be penalized for filing a complaint.

To file a privacy complaint with us, you may contact Member Services at the telephone number on the back of your member ID Card, or you may contact the Privacy Office as follows:

Independence Blue Cross
Privacy Office
P.O. Box 41762
Philadelphia, PA 19101 - 1762

Fax: (215) 241-4023 or 1-888-678-7006 (toll free)
E-mail: Privacy@ibx.com
Phone: 215-241-4735 or 1-888-678-7005 (toll free)