City & Borough of Juneau
Bartlett Regional Hospital
Juneau School District

Vision Plan on
Yukon Network

4001480

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Important Telephone Numbers

For Questions Regarding Your Medical, Dental, and Vision Benefits and Claims:

- Premera Blue Cross Blue Shield of Alaska

  Mailing Address for Claims Only:

  PO Box 91059
  Seattle, WA 98111-9159

  Mailing Address for Appeals Only:

  PO Box 91102
  Seattle, WA 98111-9202

  Telephone Numbers:

  Local and toll-free number: 800-508-4722 (TTY:711)
  Monday - Friday, 5:00 a.m. – 8:00 p.m.
  Pacific Time

For Questions Regarding Your Prescription Drug Program or to Locate an In-Network Pharmacy:

- Express Scripts
  800-391-9701
  www.express-scripts.com
  Sunday -Saturday, 24 hours a day

For Care Management:

- Prior Authorization and Emergency Notification
  800-722-4714
  Monday - Friday, 8:00 a.m. - 4:30 p.m.
  Pacific Time

For Questions Regarding Eligibility for Enrollment:

- City & Borough of Juneau Division of Risk Management
  907-586-0323
  Monday - Friday, 8:00 a.m. - 4:30 p.m.
  Alaska Time Zone

To Contact Your Confidential Employee Assistance Program:

- 800-295-9059
- 800-697-0353

To Contact Your Plan's Consultant:

- AON Consulting Inc - Seattle
  206-467-4600
  Monday - Friday, 8:00 a.m. - 5:00 p.m. Pacific Time

INTRODUCTION

This is a replacement benefit booklet. We've discovered that the benefit booklet recently provided to you contained an error. To ensure that you have complete and correct information on your benefit plan, we're replacing the benefit booklet previously available to you. Please discard the prior version.

Welcome to the City & Borough of Juneau/Bartlett Regional Hospital/Juneau School District Health Benefit Plan. Our program is designed to provide comprehensive protection for our employees and their covered family members. At the same time, the program has been designed to encourage the careful use of health care services.

We sincerely wish that you and your family enjoy good health, but in the event you need to use the Health Benefit Plan, the benefits are excellent. We believe it is one of the best programs available anywhere.

The City & Borough of Juneau/Bartlett Regional Hospital/Juneau School District Health Benefit Plan is an "in-network provider arrangement"; it is based on agreements that certain providers have made with Premera Blue Cross Blue Shield of Alaska. The agreements with In-Network Providers mean lower fees charged for hospital and medical services furnished by In-Network Providers to our enrollees.

The In-Network Provider program is designed to lower your out-of-pocket expense. Therefore, you are encouraged to use In-Network Providers.

Please take time to become familiar with the benefits the program offers. Many terms have specific meanings as used throughout the book. Please refer to the ***Definitions*** section at the end of the booklet for clarification. **We suggest you review this booklet carefully**.

Our program is administered by Premera Blue Cross Blue Shield of Alaska. If you have questions regarding your coverage or how benefits have been paid, Premera Blue Cross Blue Shield of Alaska encourages you to contact their Customer Service Department at:

Local and toll-free number: 800-508-4722 (TTY: 771)
Monday - Friday, 8:00 a.m. – 5:00 p.m.
Pacific Standard Time

Your claims correspondence can be sent to:

Premera Blue Cross Blue Shield of Alaska
PO Box 91059
Seattle, WA 98111-9159

If at any time you have questions concerning your eligibility, please contact the CBJ Risk Management at (907) 586-0321.

This plan will comply with the 2010 federal health care reform law, called the Affordable Care Act (see *Definitions*). If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, including changes which become effective on the beginning of the calendar year, this plan will comply with them even if they are not stated in this booklet or if they conflict with statements made in this booklet.

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SUMMARY OF YOUR BENEFITS

This is a summary of your benefits for covered vision services. Your costs are subject to all of the following.

- The **allowed amount**. This is the most this vision plan allows for a covered vision service. For providers that do not have agreements with us, you are responsible for any amounts over the allowed amount.
- The **coinsurance**. This is a defined percentage of allowed amounts for covered vision services and supplies you receive. The benefit level provided by this vision plan and the remaining percentage you are responsible for, not including required copays, are both referred to as "coinsurance".
- The **copay**. This is a fixed up-front dollar amount that you're required to pay for each occurrence of certain covered vision services. Your vision provider of care may ask you to pay the copay at the time of service. Unless stated otherwise, benefits subject to a copay aren't subject to your deductible or coinsurance if any.
- **Conditions, time limits and maximum limits**. This vision plan has certain conditions, time limits and maximum limits that are described in this booklet. Some services have special rules. See ***Covered Services*** for these details.

	In-Network Provider	Out-of-Network Provider
Vision Care		
Adult Vision Benefits Vision services are provided for covered members 19 years of age or older. For vision benefits provided for members under age 19, see the Pediatric Vision Benefit. • **Vision exams** This benefit provides one routine vision exam per member each plan year. • **Vision hardware** The plan pays allowed amounts including any applicable sales tax, shipping and handling costs up to a maximum benefit of $200 per member each plan year. 2 glass lenses per plan year are allowed and do not accrue to the $200 maximum.	100% of the allowed amount 100% of the allowed amount	
Pediatric Vision Benefit This benefit covers vision services for covered children under the age of 19. • **Vision Exam** Benefits are provided for one routine eye exam per plan year. • **Vision Hardware** Benefits are provided for: • 1 pair of frames and lenses per plan year, or • 1 pair of hard contact lenses per plan year, or 12-month supply of disposable contact lenses per plan year	100% of the allowed amount No cost-shares	

STARTING OUT IN THE PROGRAM

WHO IS ELIGIBLE FOR COVERAGE?

CBJ Employees

Start effective on the first day of the pay period following their date of hire when an employee is eligible to enroll in the plan, and chooses to "enroll" in the plan, if they satisfy the following:

- They become an active full-time employee, including a new seasonal employee, who regularly works a minimum of 37 1/2 hours per week
- They become an active permanent/probationary: part-time employee, seasonal employee, or exempt employee working less than full time and who regularly works a minimum of 780 hours per year and a minimum of 15 hours per week, and they agree to pay their portion of the premium, which will be pro-rated depending on the number of hours worked per pay period
- They become an Assembly Member

Bartlett Regional Hospital Employees

Start effective on the first day of the pay period following their date of hire when an employee is eligible to enroll in the plan, and chooses to "enroll" in the plan, if they satisfy the following:

- They become an active-full-time employee, including a new seasonal employee, who regularly works a minimum of 72 hours per pay period
- They become an active permanent/probationary: part-time employee, or exempt employee working less than full time and who regularly works a minimum of 832 hours per year and a minimum of 16 hours per week, and they agree to pay their portion of the premium, which will be pro-rated depending on the number of hours worked per pay period

Juneau School District Employees

For school district employees refer to your individual union contract

Dependent Eligibility

An "eligible dependent" is defined as one of the following:

- The lawful spouse of the employee, unless legally separated.
- The domestic partner of the subscriber. If all requirements are met, as stated in the signed "Affidavit of Domestic Partnership," all rights and benefits afforded to a "spouse" under this plan except eligibility for COBRA coverage will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term "establishment of the domestic partnership" shall be used in place of "marriage," and the term "termination of the domestic partnership" shall be used in place of "legal separation" and "divorce."
- An eligible child under 26 years of age. An eligible child is one of the following:
  - A natural offspring of either or both the employee or spouse
  - A legally adopted child of either or both the employee or spouse; or
  - A child "placed" with the employee for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the employee of a legal obligation for total or partial support of a child in anticipation of adoption of such child.
  - A minor for whom the subscriber or spouse has a legal guardianship. There must be a court order signed by a judge, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

Coverage may continue beyond the limiting age shown in the ***Dependent Eligibility*** section for a dependent child who cannot support himself or herself because of a developmental or physical disability. The child will continue to be eligible if all the following are met:

- The child became disabled before reaching the limiting age

- The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the employee for support and maintenance
- The employee remains covered under this program
- The child's required contributions, if any, continue to be paid
- Within 31 days of the child reaching the limiting age, the employee furnishes the Claims Administrator with a "Request for Certification of Handicapped Dependent" form. The Plan Administrator must approve the request for certification for coverage to continue; and
- The employee provides the Claims Administrator with proof of the child's disability and dependent status when requested. The Claims Administrator will not ask for proof more often than once a year after the two-year period following the child's attainment of the limiting age.

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

When the employee becomes eligible to enroll, they **must** complete an enrollment form or waive form (with proof of other coverage) and if necessary an affidavit of marriage for themselves and any eligible dependents within 30 days.

You or your eligible dependents may become eligible to enroll in this program on the following dates or may enroll once annually unless additional family status changes occur during the plan year:

- For the employee and existing eligible family members, the date the employee meets the employee eligibility requirements.
- For a spouse and eligible children that they meet the criteria outlined in the affidavit of marriage.
- For a natural newborn child born on or after the employee's effective date, the child's birth date.
- For an adoptive child, the date the child is placed with the employee for the purpose of legal adoption.

We must receive completed enrollment applications and required subscription charges within 30 days of the date the applicant becomes eligible to enroll, or in the case of a spouse and eligible children acquired through marriage, 30 days from the date they become eligible to enroll as explained above. If we don't receive the enrollment application within 30 days of the date you became eligible, none of the dates above will apply. Please see ***Special Enrollment*** below.

For adoptive and natural newborn children we must receive completed enrollment applications and required subscription charges within 60 days of the date the applicant becomes eligible to enroll.

Children Covered Under Medical Child Support Orders Or Legal Guardianship

When we receive the completed enrollment application within 30 days of the date of the medical child support order or legal guardianship, coverage for an otherwise eligible child that is required under the order (by the court) will become effective on the date of the order. Otherwise, coverage will become effective on the first of the month following the date we receive the application for coverage. The enrollment application may be submitted by the subscriber, the child's custodial parent, a state agency administering Medicaid, or the state child support enforcement agency. When subscription charges being paid do not already include coverage for dependent children, such charges will begin from the child’s effective date. Please contact your Group for detailed procedures.

Family and Medical Leave/Alaska Family Leave

The City & Borough of Juneau and Bartlett Regional Hospital/Juneau School District adheres to the provisions of the Family and Medical Leave Act (FMLA) and the Alaska Family Leave Act (AFLA) for all Employees that meet eligibility requirements.

Eligible Employees on Family Medical Leave Act who go into a leave without pay status will continue to receive health insurance benefits as if they were continuing to work; including an obligation to pay their share of the premium. Eligible Employees who have exhausted benefits under the FMLA but remain eligible for benefits under the AFLA and are in a leave without pay status are eligible for continuing health insurance benefits but are obligated to pay the full premium.

You have a right under the Family and Medical Leave Act (FMLA) for up to 18 weeks of unpaid leave in a 12-month period for the reasons listed below.

- For the birth of the employee's child or for the placement of a child with the employee through adoption or foster care
- When an employee is needed to care for the employee's child, spouse or parent who had a serious health condition
- When an employee is unable to perform the functions of his or her job due to a serious health condition.
- Due to a qualifying exigency or for care of an injured covered service member under the National Defense Authorization Act

  Employees who have worked for CBJ, Bartlett or Juneau School District long enough to be eligible for coverage under the FMLA policy can, if absent for one of the reasons listed above, continue to receive health insurance benefits even if they run out of personal leave and go into Leave Without Pay. The employees' obligation to pay their share of the contribution continues, just the same as if they were working, but the employer will continue to pay its contribution towards the health benefits. When the FMLA is over, the employee will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment unless the position has been laid off.

  If an employee chooses not to return to work following FMLA, the employee may be required to reimburse CBJ, Bartlett or Juneau School District for health benefit contributions it made during the entire period of FMLA. Reimbursement may not be required if the failure to return to work is due to: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA; or 2) other circumstances beyond the employee's control.

For more information about the Family/Medical Leave Policy, please contact your Human Resources Department.

- **Bartlett Regional Hospital employees**: 907-796-8418
- **City and Borough employees**: 907-586-5250
- **Juneau School District employees**: 907-523-1781

Donation of Leave

CBJ Employees – Refer to your Personnel Policies or contact the Human Resources Department at 907-586-5250 for more information.

Bartlett Employees – Refer to your Human Resources Department at 907-796-8418.

Juneau School District – Refer to your Payroll Department at 907-823-1781

Re-Enrollment

If an employee terminates coverage during the plan year, and returns to work within that same plan year, all credits and deductibles previously satisfied will be reinstated.

Late Enrollment

If you decline enrollment for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

When we receive the employee and/or dependent's completed enrollment application and any required subscription charges within 30 days of the date such other coverage ended, coverage under this plan will become effective on the first of the month following receipt of the employee and/or dependent's enrollment application.

When we don't receive the employee and/or dependent's completed enrollment application within 30 days of the date prior coverage ended, refer to ***Enrollment***.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. Please contact your Plan Administrator for instructions on other special enrollments.

SPECIAL ENROLLMENT

Involuntary Loss Of Other Coverage

If an employee and/or dependent doesn't enroll in this plan or another plan sponsored by the Group when first eligible because they aren't required to do so, that employee and/or dependent may later enroll in this plan outside of the annual open enrollment period if each of the following requirements is met:

- The employee and/or dependent were covered under group health coverage or a health insurance program at the time coverage under the Group's plan is offered
- The employee and/or dependent's coverage under the other group health coverage or health insurance program ended as a result of one of the following:
  - Loss of eligibility for coverage (including, but not limited to, the result of legal separation, divorce, death, termination of employment or the reduction in the number of hours of employment)
  - Termination of employer contributions toward such coverage
  - The employee and/or dependent were covered under COBRA at the time coverage under this plan was previously offered and COBRA coverage has been exhausted.

An eligible employee who qualifies as stated above may also enroll all eligible dependents. When only an eligible dependent qualifies for special enrollment, but the eligible employee is not enrolled in any of the Group's plans or is enrolled in a different plan sponsored by the Group, the employee is also allowed to enroll in this plan in order for the dependent to enroll.

When we receive the employee and/or dependent's completed enrollment application and any required subscription charges within 60 days of the date such other coverage ended, coverage under this plan will be effective on the first day of the month following the date the other coverage was lost.

If we do not receive the employee and/or dependent's completed enrollment application within the required 60 days, you and/or your dependents may not enroll until the next group open enrollment period. Please see ***Open Enrollment*** below.

Subscriber And Dependent Special Enrollment

An eligible employee and otherwise eligible dependents who previously elected not to enroll in any of the employer's group health plans when such coverage was previously offered, may enroll in this plan at the same time a newly acquired dependent is enrolled under ***Enrollment*** in the case of marriage, birth, adoption, or placement for adoption. The eligible employee may also choose to enroll alone, enroll with some or all eligible dependents or change plans, if applicable.

Please note: If a newborn child is born to a dependent child of the subscriber or spouse, and the dependent child was not covered under the plan prior to the newborn's birth, the newborn is not eligible to be enrolled and no Special Enrollment event has occurred.

OPEN ENROLLMENT

If you're not enrolled when you first become eligible, or as allowed under "Special Enrollment" above, you cannot be enrolled until the Group's next "Open Enrollment" period. An open enrollment period occurs once a year unless otherwise agreed upon between the Group and us. During this period, eligible employees and their dependents can enroll for coverage under this plan.

Subscriber And Dependent Special Enrollment With Medicaid and Children's Health Insurance Program (CHIP) Premium Assistance

You and your dependents may have special enrollment rights under this plan if you meet the eligibility requirements described under ***When Does Coverage Begin?*** and:

- You qualify for premium assistance for this plan from Medicaid or CHIP; or
- You no longer qualify for health care coverage under Medicaid or CHIP.

If you and your dependents are eligible as outlined above, you qualify for a 60-day special enrollment period. This means that you must request enrollment in this plan within 60 days of the date you qualify for premium assistance under Medicaid or CHIP or lose your Medicaid or CHIP coverage.

Coverage under this plan for the eligible employee and any dependents will start on the first of the month following:

- The date the eligible employee and any dependents qualify for Medicaid or CHIP premium assistance; or
- The date the eligible employee and any dependents lose coverage under Medicaid or CHIP.

The eligible employee and any dependents may be required to provide proof of eligibility from the state for this special enrollment period.

If we don't receive the enrollment application within the 60-day period as outlined above, you will not be able to enroll until the next open enrollment period.

CHANGES IN COVERAGE

No rights are vested under this plan. The Group may change its terms, benefits, and limitations at any time. Changes to this plan will apply as of the date the change becomes effective to all members and to eligible employees and dependents who become covered under this plan after the date the change becomes effective.

PLAN TRANSFERS

Subscribers (with their enrolled dependents) may be allowed to transfer to this plan from another plan offered by the Group. Transfers also occur if the Group replaces another vision plan (with us) with this plan. Also, we may replace the Group's current contract for this plan with an updated one from time to time. All transfers to this plan must occur during "open enrollment" or on another date set by the Group.

When you transfer from the Group's other plan, and there is no lapse in your coverage, the following provisions that apply to this plan will be reduced to the extent they were satisfied and/or credited under the prior plan:

- Plan year deductible
- Benefit maximums
- Lifetime maximums

In the event an employee enrolls for coverage under a different vision plan also offered by the Group, enrollment for coverage under this plan can only be made during the Group's next open enrollment period.

This provision doesn't apply to transfers from plans not offered by us.

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

Coverage will end without notice on the date on which one of these events occurs:

- For the subscriber and dependents when any of the following occur:
  - The next required monthly charge for coverage isn't paid when due or within the grace period
  - The subscriber dies or is otherwise no longer eligible as a subscriber. If the subscriber dies, coverage for spouse and dependents will continue through the end of the month of the employee's death. After the expiration of the coverage, the spouse and/or dependents are eligible for COBRA coverage. See ***COBRA*** for details.
  - In the case of a collectively bargained program, the employer fails to meet the terms of an applicable collective bargaining agreement or to employ employees covered by a collective bargaining agreement
- For a spouse when his or her marriage to the subscriber is annulled, or when he or she becomes legally separated or divorced from the subscriber
- For a child when he or she no longer meets the requirements for dependent coverage shown in ***Who Is Eligible For Coverage?***
- For fraud or intentional misrepresentation of material fact under the terms of the coverage by the subscriber or the subscriber's dependents
- **CBJ Employees –** Coverage will end on the last day of the pay period following their date of termination or ceasing to be an eligible employee.

The subscriber must promptly notify the Group when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan.

PLAN TERMINATION

No rights are vested under this plan. The Group is not required to keep the plan in force for any length of time. The Group reserves the right to change or terminate this plan, in whole or in part, at any time with no liability. Plan changes are made as described in ***Changes In Coverage*** in this booklet. If the plan were to be terminated, you would only have a right to benefits for covered care you receive before the plan's end date.

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

Coverage may continue beyond the limiting age shown in the ***Dependent Eligibility*** section for a dependent child who cannot support himself or herself because of a developmental or physical disability. The child will continue to be eligible if all the following are met:

- The child became disabled before reaching the limiting age
- The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the subscriber for support and maintenance
- The subscriber remains covered under this plan
- The child's subscription charges, if any, continue to be paid
- Within 31 days of the child reaching the limiting age, the subscriber furnishes the Group with a Request for Certification of Handicapped Dependent form. The Group must approve the request for certification for coverage to continue.
- The subscriber provides proof of the child's disability and dependent status when requested. Proof won't be requested more often than once a year after the 2-year period following the child's attainment of the limiting age.

Coverage for a subscriber and enrolled dependents may be continued for up to 90 days when the Group grants the subscriber a leave of absence and subscription charges continue to be paid.

The 90-day leave of absence period counts toward the maximum COBRA continuation period, except as prohibited by the Family and Medical Leave Act of 1993.

CONTINUATION UNDER USERRA

The Uniformed Services Employment And Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights on employer-provided health care coverage) of individuals who voluntarily or involuntarily leave employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are re-employed, generally without any waiting periods or exclusions (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.

Contact your employer for information on USERRA rights and requirements. You may also contact the U.S. Department of Labor at 1-866-4-USA-DOL or visit its web site at **www.dol.gov/vets**. An online guide to USERRA can be viewed at **www.dol.gov/elaws/userra.htm**.

COBRA

When group coverage is lost because of a "qualifying event" shown below, federal laws and regulations known as "COBRA" require the Group to offer qualified members an election to continue their group coverage for a limited time. Under COBRA, a qualified member must apply for COBRA coverage within a certain time period and may also have to pay a monthly charge for it.

The plan will provide qualified members with COBRA coverage when COBRA's enrollment and payment requirements are met. But, coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this plan. The Group, **not us**, is responsible for all notifications and other duties assigned by COBRA to the "plan administrator" within COBRA's time limits.

The following summary of COBRA coverage is taken from COBRA. Members' rights to this coverage and obligations under COBRA automatically change with further amendments of COBRA by Congress or interpretations of COBRA by the courts and federal regulatory agencies.

Qualifying Events and Length of Coverage

Please contact the Group immediately when one of the qualifying events highlighted below occurs. The continuation periods listed extend from the date of the qualifying event.

Please note: Covered grandchildren have the same rights to COBRA coverage as covered children.

Please note: Covered domestic partners and their children who don't qualify as dependent children of the subscriber, as stated in ***Dependent Eligibility*** earlier in this booklet, aren't eligible for COBRA coverage under this plan.

- The Group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of 1 of 2 qualifying events:
  - **The subscriber's work hours are reduced.**
  - **The subscriber's employment terminates, except for discharge due to actions defined by the Group as gross misconduct.**

  However, if one of the events listed above follows the covered employee's entitlement to Medicare by less than 18 months, the Group must offer the covered spouse and children an election to continue coverage for up to 36 months starting from the date of the Medicare entitlement. This happens only if the event would've caused a similar dependent who wasn't on COBRA coverage to lose coverage under this plan.
- COBRA coverage can be extended if a member who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.
- The Group must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:
  - **The subscriber dies.**
  - **The subscriber and spouse legally separate or divorce.**
  - **The subscriber becomes entitled to Medicare.**
  - **A child loses eligibility for dependent coverage.**

  In addition, the occurrence of one of these events during the 18-month period described above can extend that period for a continuing dependent. This happens only if the event would have caused a similar dependent who was not on COBRA coverage to lose coverage under this plan. The extended period will end no later than 36 months from the date of the qualifying event.

Conditions of COBRA Coverage

For COBRA coverage to become effective, all of the requirements below must be met:

You Must Give Notice Of Some Qualifying Events

The plan will offer COBRA coverage only after the Group receives timely notice that a qualifying event has occurred.

The subscriber or affected dependent must notify the Group in the event of a divorce, legal separation, child's loss of eligibility as a dependent, or any second qualifying event which occurs within the 18-month period as described in "Qualifying Events And Lengths Of Coverage." The subscriber or affected dependent must also notify the Group if the Social Security Administration determines that the subscriber or dependent was disabled on any of the first 60 days of COBRA coverage. You also have the right to appoint someone to give the Group this notice for you.

If the required notice is not given or is late, the qualified member loses the right to COBRA coverage. Except as described below for disability notices, the subscriber or affected dependent has 60 days in which to give notice to the Group. The notice period starts on the date shown below.

- For determinations of disability, the notice period starts on the **later** of: 1) the date of the subscriber's termination or reduction in hours; 2) the date qualified member would lose coverage as the result of one of these events; or 3) date of the disability determination. **Please note: Determinations that a qualified member is disabled must be given to the Group before the 18-month continuation period ends. This means that the subscriber or qualified member might not have the full 60 days in which to give the notice.** Please include a copy of the determination with your notice to the Group.

Note: The subscriber or affected dependent must also notify the Group if a qualified member is deemed by the Social Security Administration to no longer be disabled. See "When COBRA Coverage Ends."

- For the other events above, the 60-day notice period starts on the **later** of: 1) the date of the qualifying event, or 2) the date the qualified member would lose coverage as a result of the event.

Important Note: The Group must tell you where to direct your notice and any other procedures that you must follow. If the Group informs you of its notice procedures after the notice period start date above for your qualifying event, the notice period will not start until the date you are informed by the Group.

The Group must notify qualified members of their rights under COBRA. If the Group has named a third party as its plan administrator, the plan administrator is responsible to notify members on behalf of the group. In such cases, the Group has 30 days in which to notify its plan administrator of a subscriber's termination of employment, reduction in hours, death or Medicare entitlement. The plan administrator then has 14 days after it receives notice of a qualifying event from the Group (or from a qualified member as stated above) in which to notify qualified members of their COBRA rights.

If the Group itself is the plan administrator, it has more than 14 days in which to give notice for certain qualifying events. The Group must furnish the notice required because of a subscriber's termination of employment, reduction in hours, death or Medicare entitlement no later than 44 days after the **later** of 1) the date of the qualifying event, or 2) the date coverage would end in the absence of COBRA. For all other qualifying events, the 14-day notice time limit applies.

You Must Enroll And Pay On Time

- You must elect COBRA coverage no more than 60 days after the **later** of 1) the date coverage was to end because of the qualifying event, or 2) the date you were notified of your right to elect COBRA coverage. You may be eligible for a second COBRA election period if you qualify under section 201 of the Federal Trade Act of 2002. Please contact the Group or your bargaining representative for more information if you believe this may apply to you.

  Each qualified member will have an independent right to elect COBRA coverage. Subscribers may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.
- You must send your first payment to the Group no more than 45 days after the date you elected COBRA coverage
- Subsequent monthly payments must be paid to the Group

Adding Family Members

Eligible family members may be added after the continuation period begins, but only as allowed under ***Special Enrollment*** or ***Open Enrollment*** in the ***When Does Coverage Begin?*** section. With one exception, family members added after COBRA begins aren't eligible for further coverage if they later have a qualifying event or if they are determined to be disabled as described under ***Qualifying Events And Lengths Of Coverage*** earlier in this COBRA section. The exception is that a child born to or placed for adoption with a covered employee while the covered employee is on COBRA has the same COBRA rights as family members on coverage at the time of the original qualifying event. The child will be covered for the duration of the covered employee's initial 18-month COBRA period, unless a second qualifying event occurs which extends the child's coverage. COBRA coverage is subject to all other terms and limitations of this plan.

Keep The Group Informed Of Address Changes

In order to protect your rights under COBRA, you should keep the Group informed of any address changes. It is a good idea to keep a copy, for your records, of any notices you send to the Group.

When COBRA Coverage Ends

COBRA coverage will end on the last day for which any charge for it has been paid in the monthly period in which the first of the following occurs:

- The applicable continuation period expires
- The next monthly payment isn't paid when due or within the 30-day COBRA grace period
- When coverage is extended from 18 to 29 months due to disability (please see ***Qualifying Events And Lengths Of Coverage*** in this section), COBRA coverage beyond 18 months ends if there's a final determination that a qualified member is no longer disabled under the Social Security Act. However, coverage won't end on the date shown above, but on the last day for which subscription charges have been paid in the

first month that begins more than 30 days after the date of the determination. The subscriber or affected dependent must provide the Group with a copy of the Social Security Administration's determination within 30 days after the **later** of: 1) the date of the determination, or 2) the date on which the subscriber or affected dependent was informed that this notice should be provided and given procedures to follow.

- You become covered under another group health care plan after the date you elect COBRA coverage. However, if the new plan contains an exclusion or limitation for a pre-existing condition, coverage doesn't end for this reason until the exclusion or limitation no longer applies.
- You become entitled to Medicare after the date you elect COBRA coverage
- The Group ceases to offer group health care coverage to any employee

If You Have Questions

Questions about your plan or your rights under COBRA should be addressed to the plan contacts provided by the Group. For more information about your rights under federal laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov/ebsa**. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

WHAT DO I NEED TO KNOW BEFORE I GET VISION CARE?

This section of your booklet explains the amounts you must pay for covered vision services before the benefits of this vision plan are provided. To prevent unexpected out-of-pocket expenses, it's important for you to understand the amounts you're responsible for. Please see the ***Summary of Your Benefits*** for any vision deductible, copays, coinsurance and benefit limits.

COINSURANCE

Unless stated otherwise, vision benefits subject to a copay aren't subject to your deductible, coinsurance, or coinsurance maximum, if any. Your copays and coinsurance amounts for this vision plan is shown on the ***Summary of Your Benefits***.

COVERED SERVICES?

The vision services listed in this section are covered as shown on the ***Summary of Your Benefits***. Please see the ***Summary of Your Benefits*** for your deductible, copays (if any), and coinsurance and benefit limits.

Vision Exams

Covered routine exam services include:

- Examination of the outer and inner parts of the eye
- Evaluation of vision sharpness (refraction)
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and recommendations

In addition to *What's Not Covered?* this *Vision Exams* benefit doesn't cover vision hardware or fitting examinations for contact lenses or eyeglasses. Those services are covered under the vision hardware benefit, if applicable.

Vision Hardware

Benefits for vision hardware listed below are provided when they meet all of these requirements:

- They must be prescribed and furnished by a licensed or certified vision care provider;
- They must be named in this benefit as covered; and
- They mustn't be excluded from coverage under this vision plan.

Vision hardware benefits include sales tax, shipping and handling costs and cover:

- Prescription eyeglass lenses (single vision, bifocal, trifocal, quadrafocal or lenticular)
- Frames for eyeglasses
- Prescription contact lenses (soft, hard or disposable)
- Prescription safety glasses
- Prescription sunglasses

- Special features, such as tinting or coating
- Fitting of eyeglass lenses to frames
- Fitting of contact lenses to the eyes

This benefit doesn't cover vision hardware or fitting examinations for contact lenses or eyeglasses. Those services are covered under the ***Vision Hardware*** benefit, if applicable.

Important Note! Prescribed vision hardware necessitated by surgery, injury or disease is not covered under this vision plan.

Vision hardware benefits are based on allowed amounts for covered services and supplies. Please see the ***Definitions*** section for a definition of "allowed amount." Charges for vision services or supplies that exceed what's covered under this benefit aren't covered under other benefits of this vision plan.

Pediatric Vision Benefit

This benefit covers vision services for covered children under the age of 19.

Vision Exam

Covered routine exam services include:

- Examination of the outer and inner parts of the eye
- Evaluation of vision sharpness (refraction)
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and recommendations

The Vision Exam benefit for members under 19 will provide coverage until the end of the month in which the member turns 19.

Vision Hardware

This benefit covers vision services for covered children under the age of 19.

The Vision Hardware benefit for members under 19 will provide coverage until the end of the month in which the member turns 19.

This benefit doesn't cover:

- Services or supplies that aren't named above as covered, or that are covered under other provisions of this vision plan
- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments) or light-sensitive lenses, even if prescribed
- Vision therapy, eye exercise or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics
- Supplies used for the maintenance of contact lenses
- Vision services and supplies (including hardware) received after your coverage under this benefit has ended, except when all of the following requirements are met:
  - You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this benefit or vision plan ended; and
  - You received the contact lenses; eyeglass lenses and/or frames within 30 days of the date your coverage under this benefit or vision plan ended.

EXCLUSIONS

This section of your booklet explains circumstances in which all the benefits of this vision plan are either limited or no vision benefits are provided. Vision benefits can also be affected by your eligibility. In addition, some vision benefits have their own specific limitations.

Amounts Over the Allowed Amount

This vision plan does not cover amounts over the allowed amount as defined by this vision plan for services from an out-of-network vision care provider. You will have to pay any amounts for your services that are over the allowed amount.

Benefits from Other Sources

This vision plan does not cover services that are covered by liability insurance, motor vehicle insurance, excess coverage, no fault coverage, or workers compensation or similar coverage for work-related conditions. For details, see ***Third Party Recovery*** in the ***What If I Have Other Coverage?*** section of the booklet.

Benefits That Have Been Exhausted

Services in excess of benefit limitations or maximums of this vision plan.

Broken or Missed Appointments

Charges for Records or Reports

Charges from providers for supplying records or reports, not requested for utilization management.

Complications

This vision plan does not cover complications of a non-covered service, including follow-up services or effects of those services, except services defined as emergency care. See ***Definitions***.

Cosmetic Services

Drugs, services or supplies for cosmetic services, including any direct or indirect complications and aftereffects such as reshaping normal structures of the body in order to improve or change your appearance and self-esteem and not primarily to restore an impaired function of the body

Court-Ordered Services

Services that you must get to avoid being tried, sentenced or losing the right to drive when they are not medically necessary.

Drugs And Medication

Drugs or medication, including prescription or over-the counter drugs.

Environmental Therapy

Therapy to provide a changed or controlled environment.

Experimental and Investigational Services

Experimental or investigative services or supplies. This vision plan also does not cover any complications or effects of such services.

Family Members or Volunteers

Services that you provide to yourself. It also does not cover a provider who is:

- Your spouse, mother, father, child, brother or sister
- Your mother, father, child, brother or sister by marriage
- Your stepmother, stepfather, stepchild, stepbrother or stepsister
- Your grandmother, grandfather, grandchild or the spouse of one of these people
- A volunteer

Illegal Acts, Illegal Services, and Terrorism

Illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt, as well as any services that is illegal under state or federal law.

Medical Treatment of Eye Conditions

- Benefits are not provided under this vision plan for treatment of medical conditions of the eye, including medical complications. The exceptions are glaucoma or other testing provided in conjunction with refractive eye exams. Also excluded are any prescription or non-prescription medications.

Military Service and War

Illness or injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country. This includes the air force, army, coast guard, marines, National Guard or navy. It also includes any related civilian forces or units. However, this exclusion does not apply to members of the U.S. military (active or retired) or their dependents enrolled in the TRICARE program. This vision plan will be primary to TRICARE for these members when required by federal law.

Non-Covered Services

Services or supplies:

- Ordered when this vision plan is not in effect or when the person is not covered under this vision plan
- Provided to someone other than the ill or injured member
- You are not required to pay or would not have been charged for if this vision plan were not in force
- That are not listed as covered under this vision plan

Non-Treatment Charges

- Charges for provider travel time
- Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical or vision appointments or shopping. Doing housework or chores for the member or helping the member do housework or chores.
- Arrangements in which the provider lives with the member

Provider's Licensing or Certification

This vision plan does not cover services that the provider's license or certification does not allow him or her to perform. It also does not cover a provider that does not have the license or certification that the state requires.

Services or Supplies for which You Do Not Legally Have to Pay

Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay.

Services or Supplies Not Medically Necessary

Services or supplies that are not medically necessary even if they're court-ordered. This also includes places of service, such as inpatient hospital care.

Vision Hardware

- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments) or light-sensitive lenses, even if prescribed
- Services and supplies (including hardware) received after your coverage under this vision plan has ended, except when all of the following requirements are met:
  - You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this vision plan ended; and
  - You received the contact lenses, eyeglass lenses and/or frames within 30 days of the date your coverage under this vision plan ended.

Vision Therapy

Vision therapy, eye exercise or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics, treatment or surgeries to improve the refractive character of the cornea or any results of such treatments.

Work-Related Conditions

This vision plan does not cover any illness, condition or injury for which you get benefits by law or from separate coverage for illness or injury on the job. For details, see ***Third Party Recovery*** under ***What If I Have Other Coverage?*** section of the booklet.

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER PLANS

You also may be covered under one or more other group or individual plans, such as one sponsored by your spouse's employer. This vision plan includes a "coordination of benefits" feature to handle such situations.

All of the benefits of this vision plan are subject to coordination of benefits.

If you have other coverage besides this vision plan, we recommend that you submit your claim to the primary carrier first, and then submit the claim to the secondary carrier with the primary carrier processing information. In that way, the proper coordinated benefits may be most quickly determined and paid.

Definitions Applicable To Coordination Of Benefits

To understand coordination of benefits, it's important to know the meanings of the following terms:

- **Allowable Expense** means the usual, customary and reasonable charge for any medically necessary health care service or supply provided by a licensed medical or vision care provider professional when the service or supply is covered at least in part under this vision plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Claim Determination Period** means a calendar year
- **Health Care Plan** means all of the following health care coverages, even if they don't have their own coordination provisions:
  - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
  - Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
  - Government programs that provide benefits for their own civilian employees or their dependents
  - Group coverage required or provided by any law, including Medicare. This doesn't include workers' compensation.
  - Group student coverage that's sponsored by a school or other educational institution and includes medical benefits for illness or disease

Each contract or other arrangement for coverage described above is a separate plan.

Effect On Benefits

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan is responsible for providing benefits first. This is called the "primary" plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become "secondary." When this vision plan is secondary, it will reduce its benefits for each claim so that the benefits from all health plans aren't more than the allowable vision expense for that claim.

We will coordinate benefits when you have other health care coverage that is primary over this vision plan. Coordination of benefits applies whether or not a claim is filed with the primary coverage.

Here is the order in which the plans should provide benefits:

First: A plan that doesn't provide for coordination of benefits.

Next: A plan that covers you as **other than** a dependent.

Next: A plan that covers you as a dependent. For dependent children, the following rules apply:

When the parents **aren't** separated or divorced: The plan of the parent whose birthday falls earlier in the year will be primary, if that's in accord with the coordination of benefits provisions of both plans. Otherwise, the rule set forth in the plan that doesn't have this provision shall determine the order of benefits.

When the parents **are** separated or divorced: If a court decree makes one parent responsible for paying the child's health care costs, that parent's plan will be primary. Otherwise, the plan of the parent with custody will be primary, followed by the plan of the spouse of the parent with custody, followed by the plan of the parent who doesn't have custody.

If the rules above don't apply, the plan that has covered you for the longest time will be primary, except that benefits of a plan that covers you as a laid-off or retired employee, or as the dependent of such an employee, shall be determined after the benefits of any plan that covers you as other than a laid-off or retired employee, or as the dependent of such an employee. However, this applies only when other plans involved have this provision regarding laid-off or retired employees.

If none of the rules above determines the order of benefits, the plan that's covered the employee or subscriber for the longest time will be primary.

Right Of Recovery/Facility Of Payment

The plan has the right to recover any payments that are greater than those required by the coordination of benefits provisions from one or more of the following: the persons the plan paid or for whom the plan has paid, providers of service, insurance companies, service plans or other organizations. If a payment that should have been made under this vision plan was made by another plan, the plan may also have the right to pay directly to another plan any amount that the plan should have paid. Such payment will be considered a benefit under this vision plan and will meet the plan's obligations to the extent of that payment.

This vision plan has the right to appoint a third party to act on its behalf in recovery efforts.

COORDINATING BENEFITS WITH MEDICARE

If you're also covered under Medicare, federal law determines how we provide the benefits of this vision plan. Those laws may require this vision plan to be primary over Medicare.

When this vision plan isn't primary, we'll coordinate benefits with Medicare. Benefits will be coordinated up to Medicare's allowed amount, as required by federal regulations. If the provider does not accept Medicare assignment, this allowed amount is the Medicare Limiting Charge.

THIRD PARTY RECOVERY

General

If you become ill or are injured by the actions of a third party, your vision care should be paid by that third party. For example, if you are hurt in a car crash, the other driver or his or her insurance company may be required under law to pay for your medical care.

This plan does not pay for claims for which a third party is responsible. However, the plan may agree to advance benefits for your injury with the understanding that it will be repaid from any recovery received from the third party. By accepting plan benefits for the injury, you agree to comply with the terms and conditions of this section.

In addition, the plan maintains a right of subrogation, meaning the right of the plan to be substituted in place of the member who received benefits with respect to any lawful claim, demand, or right of action against any third party that may be liable for the injury, illness or medical condition that resulted in payment of plan benefits. The third party may not be the actual person who caused the injury and may include an insurer to which premiums have been paid.

The plan administrator has discretion to interpret and to apply the terms of this section. It has delegated such discretion to Premera Blue Cross Blue Shield of Alaska and its affiliates to the extent we need in order to administer this section.

Definitions The following definitions shall apply to this section:

- **Recovery** All payments from another source that are related in any way to your injury for which plan benefits have also been paid. This includes any judgment, award, or settlement. It does not matter how the recovery is termed, allocated, or apportioned or whether any amount is specifically included or excluded as a medical expense. Recoveries may also include recovery for pain and suffering, non-economic damages, or general damages. This also includes any amounts put into a trust or constructive trust set up by or for you or your family, beneficiaries or estate as a result of your injury.
- **Reimbursement Amount** The amount of benefits paid by the plan for your injury and that you must pay back to the plan out of any recovery per the terms of this section.

- **Responsible Third Party** A third party that is or may be responsible under the law ("liable") to pay you back for your injury.
- **Third Party** A person; corporation; association; government; insurance coverage, including uninsured/underinsured motorist (UM/UIM), personal umbrella coverage, personal injury protection (PIP) insurance, medical payments coverage from any source, or workers' compensation coverage. The third party may not be the actual party who caused the injury, and may include an insurer.

  Please Note: For this section, a third party does not include other health care plans that cover you.
- **You** In this section, "you" includes any lawyer, guardian, or other representative that is acting on your behalf or on the behalf of your estate in pursuing a repayment from responsible third parties.

Exclusions

- **Benefits From Other Sources** – Benefits are not available under this plan when coverage is available through:
  - Any type of excess coverage
  - Any type of liability insurance, such as home owner's coverage or commercial liability coverage
  - Any type of no-fault coverage, such as Personal injury protection (PIP), Medical Payment coverage or Medical Premises coverage
  - Boat coverage
  - Motor vehicle medical or motor vehicle no-fault
  - School or athletic coverage
- **Work-Related Conditions** Any illness, condition or injury arising out of or in the course of employment, for which the member is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:
  - Occupational coverage required of or voluntarily obtained by the employer
  - State or federal workers compensation acts
  - Any legislative act providing compensation for work-related illness or injury

However, this exclusion doesn't apply to owners, partners or executive officers who are full-time employees of the Group if they're exempt from the above laws and if the Group doesn't furnish them with workers' compensation coverage. They'll be covered under this plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this plan.

These exclusions apply when the available or existing contract or insurance is either issued to a member or makes benefits available to a member, whether or not the member makes a claim under such coverage. Further, the member is responsible for any cost-sharing required by motor vehicle coverage, unless applicable state law requires otherwise. If other insurance is available for medical bills, the member must choose to put the benefit to use towards those medical bills before coverage under this plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be injury-related under the no-fault provisions of the contract, this plan's vision benefits will be provided.

Reimbursement and Subrogation Rights

If the plan advances payment of benefits to you for an injury, the plan has the right to be repaid in full for those benefits.

- The vision plan has the right to be repaid first and in full, without regard to lawyers' fees or legal expenses, make-whole doctrine, the common fund doctrine, your negligence or fault, or any other common law doctrine or state statute that the plan is not required to comply with that would restrict the plan's right to reimbursement in full. The reimbursement to the plan shall be made directly from the responsible third party or from you, your lawyer or your estate.
  - The plan shall also be entitled to reimbursement by asking for refunds from providers for the claims that it had already paid.
- The plan's right to reimbursement first and in full shall apply even if:
  - The recovery is not enough to make you whole for your injury.
  - The funds have been commingled with other assets. The plan may recover from any available funds without the need to trace the source of the funds.

- The member has died as a result of the injury and a representative is asserting a wrongful death or survivor claim against the third party.
- The member is a minor, disabled person, or is not able to understand or make decisions.
- The member did not make a claim for medical expenses as part of any claim or demand

- Any party who distributes your recovery funds without regard to the plan's rights will be personally liable to the plan for those funds.
- In any case where the plan has the right to be repaid, the plan also has the right of subrogation. This means that the Plan Administrator can choose to take over your right to receive payments from any responsible third party. For example, the plan can file its own lawsuit against a responsible third party. If this happens, you must co-operate with the plan as it pursues its claim.
- The plan shall also have the right to join or intervene in your suit or claim against a responsible third party.
- You cannot assign any rights or causes of action that you might have against a third party tortfeasor, person, or entity, which would grant you the right to any recovery without the express, prior written consent of the plan.

Your Responsibilities

- If any of the requirements below are not met, the plan shall:
  - Deny or delay claims related to your injury
  - Recoup directly from you all benefits the plan has provided for your injury
  - Deduct the benefits owed from any future claims
- You must notify Premera Blue Cross Blue Shield of Alaska of the existence of the injury immediately and no later than 30 days of any claim for the injury.
- You must notify the third parties of the plan's rights under this provision.
- You must cooperate fully with the plan in the recovery of the benefits advanced by the plan and the plan's exercise of its reimbursement and subrogation rights. You must take no action that would prejudice the plan's rights. You must also keep the plan advised of any changes in the status of your claim or lawsuit.
- If you hire a lawyer, you must tell Premera Blue Cross right away and provide the contact information.

  Neither the plan nor Premera Blue Cross Blue Shield of Alaska shall be liable for any costs or lawyer's fees you must pay in pursuing your suit or claim. You shall defend, indemnify and hold the plan and Premera Blue Cross Blue Shield of Alaska harmless from any claims from your lawyer for lawyer's fees or costs.
- You must complete and return to the plan an Incident Questionnaire and any other documents required by the plan.

  Claims for your injury shall not be paid until Premera Blue Cross Blue Shield of Alaska receives a completed copy of the Incident Questionnaire when one was sent.
- You must tell Premera Blue Cross Blue Shield of Alaska if you have received a recovery. If you have, the plan will not pay any more vision claims for the injury unless you and the plan agree otherwise.
- You must notify the plan at least 14 days prior to any settlement or any trial or other material hearing concerning the suit or claim.

Reimbursement and Subrogation Procedures

If you receive a recovery, you or your lawyer shall hold the Recovery funds separately from other assets until the plan's reimbursement rights have been satisfied. The plan shall hold a claim, equitable lien, and constructive trust over any and all recovery funds. Once the vision plan's reimbursement rights have been determined, you shall make immediate payment to the plan out of the recovery proceeds.

If you or your lawyer do not promptly set the recovery funds apart and reimburse the plan in full from those funds, the plan has the right to take action to recover the reimbursement amount. Such action shall include, but shall not be limited to one or both of the following:

- Initiating an action against you and/or your lawyer to compel compliance with this section.
- Withholding plan benefits payable to you or your family until you and your lawyer complies or until the reimbursement amount has been fully paid to the plan.

HOW DO I FILE A VISION CLAIM?

VISION CLAIMS

Many vision care providers will submit their bills to us directly. However, if you ever need to submit a vision claim to us, follow these simple steps:

Step 1

Complete a separate Subscriber Claim Form for each patient and each vision care provider. You can get a claim form at **premera.com**. You can also call us and we will mail a claim form to you within 10 days.

Step 2

Attach the itemized bill. The itemized bill must contain all of the following information:

- Names of the subscriber and the member who incurred the expense
- Identification numbers for both the subscriber and the Group (these are shown on the subscriber's identification card)
- Name, address and IRS tax identification number of the vision care provider
- Information about other insurance coverage
- Date of onset of the illness or injury
- Diagnosis (ICD) code
- Procedure codes (CPT-4, HCPCS, ADA, or UB-92) for each service
- Dates of service and itemized charges for each service rendered
- If the services rendered are for treatment of an accidental injury, the date, time, location, and a brief description of the accident

Step 3

If you're also covered by Medicare, and Medicare is primary, you must attach a copy of the "Explanation of Medicare Benefits."

Step 4

Check that all required information is complete. Bills received won't be considered to be claims until all necessary information is included.

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

Mail your vision claims to the address listed inside the front cover of this booklet.

You should submit all vision claims within 90 days of the start of service or within 30 days after the service is completed. We must receive vision claims:

- Within 365 days of discharge for hospital or other medical facility expenses, or within 365 days of the date on which expenses were incurred for any other services or supplies; or
- For members who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater

The vision plan won't provide benefits for claims we receive after the later of these two dates, nor will the vision plan provide benefits for vision claims which were denied by Medicare because they were received past Medicare's submission deadline. Exceptions will be allowed when required by law or regulation.

VISION CLAIMS PROCEDURE

Vision claims for benefits will be processed under the following time frames:

- If the vision claim includes all of the information we need to process the vision claim, we will process it within 30 calendar days of receipt

- If we need more information to process the vision claim, we will tell you or the vision care provider who submitted the vision claim that we need more information. We will make that request within 30 days of receipt. You or your provider will have 45 days from our notice to provide the additional information.
- Once we receive the additional information, we will process your vision claim within 15 days of the date we receive the information

When we process your vision claim, we will send a written notice explaining how the vision claim was processed. If the vision claim is denied in whole or in part, we will send a written notice that states the reason for the denial, and information on how to request an appeal of that decision.

If your provider requires a copay when you get medical services or supplies, it is not considered a claim for benefits. However, you always have the right to request and obtain from us a paper copy of your explanation of benefits in connection with such a medical service by calling Customer Service. The phone number is on the front cover of your booklet and on your Premera ID card. Or, you can visit our website, **premera.com**, for information and secure online access to vision claims information. To file a claim, please see the ***How Do I File A Claim?*** section for more detail. If your claim is denied in whole or in part, you may submit a complaint or appeal as outlined under ***Complaints and Appeals***.

At any time, you have the right to appoint someone to pursue the vision claim on your behalf. This can be a doctor, lawyer, or a friend or relative. You must notify us in writing and give us the name, address, and telephone number where your appointee can be reached.

If a vision claim for benefits or an appeal is denied or ignored, in whole or in part, or not processed within the time shown in these vision claims procedures, you may have the right to file suit in a state or federal court.

CARE RECEIVED OUTSIDE THE UNITED STATES

When you submit a vision claim for care you received outside the United States, please include whenever possible: a detailed description, in English, of the services, drugs, or supplies received; the names and credentials of the treating providers, and medical records or chart notes.

To process your foreign claim, we will convert the foreign currency amount on the claim into US dollars for claims processing.

COMPLAINTS AND APPEALS

If at any time you have questions regarding your healthcare, you may contact customer service for assistance. They are here to serve you and answer questions.

If you disagree with a decision we made or feel dissatisfied, and would like us to formally review your concerns, you can file a complaint or appeal with Premera.

WHAT IS A COMPLAINT?

Other than denial of payment for medical services or non-provision of medical services, a complaint is when you are not satisfied with customer service, quality, or access to medical service, and you want to share it with Premera.

How to file a complaint

Call customer service at 800-508-4722 (TTY:711)

Send a fax to 425-918-5592

Send the details in writing to:

Premera Blue Cross Blue Shield of Alaska
PO Box 91102
Seattle, WA 98111-9202

For complaints received in writing, we will send a written response within 30 days.

WHAT IS AN APPEAL?

An appeal is a request to review a specific decision or an adverse benefit determination Premera has made.

An adverse-benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes:

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits

- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective

What you can appeal

Claims and prior authorization	Payment	Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits.
	Denied	Coverage of your service, supply, device or prescription was denied or partially denied. This includes prior authorization denials.

Appeal Levels

You have the right to three levels of appeals:

Appeal Level	What it means	Deadline to appeal
Level 1 (Internal)	This is your first appeal. Premera will review your appeal.	180 days from the date you were notified of our decision.
Level 2 (Internal)	If we deny your Level 1 appeal, you can appeal a second time. Premera will review your appeal.	60 days from the date you were notified of our Level 1 appeal decision.
External	If we deny your Level 1 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal. OR You can ask for an IRO review if Premera has not made a decision by the deadline for the Level 1 appeal. There is no cost to you for an external appeal.	180 days from the date you were notified of our Level 1 appeal decision. OR 180 days from the date the response to your Level 1 appeal was due, if you did not get a response or it was late.

HOW TO SUBMIT AN APPEAL IN WRITING

Step 1. **Get the form**	• Complete the **Member Appeal Form**, you can find it on **premera.com** or call customer service to request a copy. If you need help submitting an appeal, or would like a copy of the appeals process, call customer service at 800-508-4722 (TTY:711)
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your doctor. Within 3 working days, we will confirm in writing that we have your request. • If you would like someone to appeal on your behalf, including your provider, complete a **Member Appeal Form** with authorization, you can find it on **premera.com**. We can't release your information without this form.
Step 3. **Send in my appeal**	To help process your appeal, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross Blue Shield of Alaska Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 Fax to 425-918-5592

Note: You may also call customer service to verbally submit an appeal.

If you would like to review the information used for your appeal, please send us a request in writing to:

Premera Blue Cross Blue Shield of Alaska
Attn: Appeals Coordinator
PO Box 91102
Seattle, WA 98111
Fax: 425-918-5592

APPEAL RESPONSE TIME LIMITS

We'll review your appeal and send a decision in writing within the time limits below. The timeframes are based on what the appeal is about, not the appeal level. At each level, Premera representatives who have not reviewed the case before will review and make a decision. Medical review denials will be reviewed by a medical specialist.

Level II internal appeals will be reviewed by a panel of people who were not part of the Level I internal appeal. You may take part in the level II panel meeting in person or by phone. Please call us for more details about this process.

Type of appeal	When to expect a response
Urgent appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing.
All other (internal) appeals	Within 30 days
External appeals	Urgent appeals within 72 hours Other IRO appeals within 45 days from the date the IRO gets your request

WHAT IF YOU HAVE ONGOING CARE

Ongoing care is continuous treatment you are currently receiving, such as residential care, care for a chronic condition, in-patient care and rehabilitation.

If you appeal a decision that affects ongoing care because we've determined the care is not or no longer medically necessary, benefits will not change during the appeal period. Your benefits during the appeal period should not be taken as a change of the initial denial. If our decision is upheld, you must repay all amounts we paid for ongoing care during the appeal review.

WHAT IF IT'S URGENT

If your condition is urgent, you will get our response sooner. Urgent appeals are only available for services you are currently receiving or have not yet received. Examples of urgent situation are:

- You are requesting coverage for inpatient or receiving emergency services that you are currently receiving
- Your life or health is in serious danger or, a delay in treatment would cause you to be in severe pain that you cannot bear, as determined by our medical professionals or your treating physician

If your situation is urgent, you may ask for an expedited external appeal at the same time you request an expedited internal appeal.

HOW TO ASK FOR AN EXTERNAL REVIEW

External reviews will be done by an Independent Review Organization (IRO).

	We will send you an External Review Application Form authorizing the release of your medical records to an IRO with the written decision of your internal appeal.
Step 1. **Complete the form**	• External appeals are available only for decisions involving a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the service or treatment you received. • You must include the signed **External Review Application Form** you received from us. You may also include medical records and other information.

Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your external review. This may include medical records and other information. • You must file your request for external review with the Alaska Division of Insurance within 180 days of the date you got our internal appeal letter. You can request an extension of the 180-day deadline by sending the Alaska Division of Insurance a written request that includes the reason why you believe an extension should be granted.
Step 3. **Send in my external review request**	• The Alaska Division of Insurance will provide your request to Premera within one working day. Premera will complete a preliminary review within five working days to determine whether the request is eligible for external appeal. • For urgent external appeals, Premera will complete the preliminary review immediately. Premera will notify you, your authorized representative, and the Alaska Division of Insurance in writing of the results of our preliminary review within one day after we have completed it. • If your request is eligible for external appeal, the Alaska Division of Insurance will assign an IRO to review your appeal. We will forward your medical records and other information to the IRO. If you have additional information on your appeal, you may send it to the IRO. • If the request is not complete, Premera will notify you, your authorized representative, and the Alaska Division of Insurance in writing of what information or materials are needed to make the request complete. • If the request is not eligible for external appeal, Premera will notify you or your authorized representative and the Alaska Division of Insurance in writing of the reasons why the request is not eligible for external review. If you do not agree with this decision, you may appeal to the Director of the Alaska Division of Insurance.

External appeals are also available for decisions related to Premera's compliance with protections established by the No Surprises Act (NSA) such as:

- Cost-sharing and surprise billing for emergency services
- Cost-sharing and surprise billing protections related to care you received from non-participating providers at participating facilities
- Your condition to receive notice and provide informed consent to waive NSA protections; and
- If a claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to patient cost-sharing and surprise billing.
  - These reviews will be referred to CMS for the HHS-Administered Federal External Review Process.

ONCE THE IRO DECIDES

For urgent appeals, the IRO will inform you and the plan immediately..

Premera will accept the IRO decision.

If the IRO:

- Reverses our decision, we will apply their decision quickly
- Stands by our decision, there is no further appeal. However, you may have other steps you can take under state or federal law, such as filing a lawsuit.

If you have questions about a denial of a claim or your appeal rights, you may call Customer Service at the number listed on your Premera ID card.

If your plan is governed by the Federal Employee Retirement Income Security Act of 1974 (ERISA), you can contact the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor. The phone number is 866-444-EBSA (3272).

OTHER INFORMATION ABOUT THIS VISION PLAN

This section tells you about how this vision plan is administered. It also includes information about federal and state requirements we and the Group must follow and other information that must be provided to you.

Conformity With The Law

If any provision of the vision plan or any amendment is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the plan will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Evidence Of Medical Necessity

We have the right to require proof of medical necessity for any services or supplies you receive before benefits under this vision plan are provided. You or your vision care providers may submit this proof. No benefits will be available if the proof isn't provided or acceptable to the vision plan.

Health Care Providers - Independent Contractors

All health care providers who provide services and supplies to a member do so as independent contractors. None of the provisions of this plan or the contract between Premera and the Group are intended to create, nor shall they be deemed or construed to create, any employment or agency relationship between Premera and the Group and the provider of service other than that of independent contractors.

ID Card

If you need a replacement Premera ID card, call our customer service or visit our website at www.premera.com. If coverage under the contract terminates, your Premera ID card will no longer be valid.

Intentionally False Or Misleading Statements

If this vision plan's benefits are paid in error due to any intentionally false or misleading statements, the vision plan is entitled to recover these amounts.

If you make any intentionally false or misleading statements on any application or enrollment form that affects your acceptability for coverage, we may, as directed by the Group:

- Deny your vision claim;
- Reduce the amount of benefits provided for your vision claim; or
- Void your vision coverage under this vision plan. (Void means to cancel vision coverage back to its effective date as if it had never existed at all.) Your vision coverage cannot be voided based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact that affects your acceptability for coverage.

Limitations Of Liability

The vision plan, the Group and Premera Blue Cross Blue Shield of Alaska are not liable for any of the following:

- Situations such as epidemics or disasters that prevent members from getting the care they need
- The quality of services or supplies received by members, or the regulation of the amounts charged by any provider, since all those who provide care do so as independent contractors
- Providing any type of hospital, medical, dental, vision or similar care
- Harm that comes to a member while in a provider's care
- Amounts in excess of the actual cost of services and supplies
- Amounts in excess of this vision plan's maximums. This includes recovery under any claim of breach.
- General or special damages including, without limitation, alleged pain, suffering, mental anguish or consequential damages

Member Cooperation

You're under a duty to cooperate with us and the Group in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us and the Group in the event of a lawsuit.

Notice Of Information Use And Disclosure

We may collect, use or disclose certain information about you. This protected personal information (PPI) may include medical information, or personal data such as your address, telephone number or Social Security number. We may receive this information from or release it to vision care providers, insurance companies or other sources.

This information is collected, used or disclosed for conducting routine business operations such as:

- Underwriting and determining your eligibility for benefits and paying claims (we do not use genetic information for underwriting or enrollment purposes);
- Coordinating benefits with other health care plans;
- Conducting care management, personal health support programs or quality reviews; and,
- Fulfilling other legal obligations that are specified under the vision plan and our administrative service contract with the Group

This information may also be collected, used or disclosed as required or permitted by law.

To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it.

If a disclosure of PPI isn't related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization.

You have the right to request inspection and /or amendment of records retained by us that contain your PPI. Please contact our Customer Service Department and ask that a representative mail a request form to you.

Notice Of Other Coverage

As a condition of receiving benefits under this vision plan, you must notify us of:

- Any legal action or claim against another party for a condition or injury for which the vision plan provides benefits, and the name and address of that party's insurance carrier
- The name and address of any insurance carrier that provides:
- Personal injury protection (PIP)
- Underinsured motorist coverage
- Uninsured motorist coverage
- Any other insurance under which you are or may be entitled to recover compensation
- The name of any group or individual insurance plans that cover you

Notices

Any notice we're required to submit to the Group or subscriber will be considered to be delivered if mailed to the Group or subscriber, at the most recent address appearing on our records. We'll use the date of postmark in determining the date of our notification. If you are required to submit notice to us, it will be considered delivered on the postmark date or the date we receive it, if not postmarked.

Recovery Of Claims Overpayments

On behalf of the vision plan, we have the right to recover amounts the vision plan has overpaid in error. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of his or her dependents (even if the original payment wasn't made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider who doesn't have a contract with us. The vision plan may also exercise the right to delegate all or part of the responsibility for recoveries to another third party.

The vision plan will give written notice to the subscriber, or any other payee, including a provider at least 30 calendar days before the plan seeks recovery of an overpayment. The notice will include how to identify the specific claim and the specific reason for the recovery. You have the right to challenge the recovery of overpayment. The vision plan may also exercise the right to delegate all or part of the responsibility for recoveries to another third party.

Right To And Payment Of Benefits

Benefits of this vision plan are available only to members. Except as required by law, we will not honor any attempted assignment, garnishment or attachment of any right of this vision plan. In addition, members may not assign a payee for claims, payments or any other rights of this vision plan.

At our option only and in accordance with the law, we may pay the benefits of this vision plan to:

- The subscriber
- A provider
- A health insurance carrier
- The member
- Another party legally entitled under federal or state medical child support laws
- Jointly to any of the above

Payment to any of the above satisfies the vision plan's obligation as to payment of benefits.

Venue

All suits and legal proceedings, including arbitration proceedings, brought against us, the vision plan or the Group by you or anyone claiming any right under this vision plan must be filed:

- Within three years of the date the rights or benefits claimed under this vision plan were denied in writing, or of the completion date of the independent review process if applicable; and
- In a mutually agreed upon location

DEFINITIONS

The terms listed below have specific meanings under this vision plan.

Accidental Injury

Physical harm caused by a sudden and unforeseen event at a specific time and place. It's independent of illness, except for infection of a cut or wound.

Adverse Benefit Determination

An adverse benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes:

- A member's or applicant's eligibility to be or stay enrolled in this vision plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective

Allowed Amount

The allowed amount shall mean one of the following:

- **Vision Care Providers In Alaska and Washington Who Have Agreements With Us**

  For any given service or supply, the allowed amount is the lesser of the following:

  - The vision care provider's billed charge; or
  - The fee that we have negotiated as a "reasonable allowance" for medically necessary covered services and supplies.

  Contracting vision care providers agree to seek payment from us when they furnish covered services to you. You'll be responsible only for any applicable deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this vision plan.

- **Vision Care Providers Outside Alaska and Washington Who Have Agreements With Other Blue Cross Blue Shield Licensees**

  For covered services and supplies received outside Alaska and Washington or in Clark County, Washington, allowed amounts are determined as stated in the ***What Do I Do If I'm Outside Alaska and Washington?*** section in this booklet.

- **Vision Care Providers in Alaska Who Don't Have Agreements With Us Or Another Blue Cross Blue Shield Licensee**

  The allowed amount shall be defined as indicated below. When you get services from a provider who does not have an agreement with us or another Blue Cross Blue Shield Licensee, you are responsible for any amounts not paid by us, including amounts over the allowed amount, except for emergency serviced as described below.

For Services and Supplies Received Within Our Service Area:

In determining the allowed amount, we establish a profile of billed charges, using statistically creditable data for a period of 12 months by examining the range of charges for the same or similar service from providers within each geographical area for which we receive claims. The allowable will be no less than 80th percentile of billed charges for that service. If we are unable to obtain sufficient data from a given geographical area, we will use a wider geographical area. If inclusion of the wider geographical area still does not provide sufficient data, we will set the allowed amount to no less than the equivalent of the 80th percentile or no lower than 250% of Medicare allowed amounts for the same services or supplies, whichever is greater.

Services and Supplies from Professional Providers: The allowed amount will be no less than the 80th percentile of billed charges as determined from a profile derived using the methodology described above.

- **Vision Care Providers Outside of Alaska Who Don't Have Agreements With Us or Another Blue Cross Blue Shield Licensee**

  The allowed amount for providers outside of Alaska is the least of the three amounts shown below.

  - An amount that is no less than the lowest amount the plan pays for the same or similar service from a comparable provider that has a contracting agreement with us
  - 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
  - The provider's billed charges.

  If applicable law requires a different allowed amount than the least of the three amounts above, this vision plan will comply with that law.

- **For Services and Supplies Received Within Our Service Area:**

  In determining the allowed amount, we establish a profile of billed charges, using statistically creditable data for a period of 12 months by examining the range of charges for the same or similar service from vision care providers within each geographical area for which we receive claims. The allowable will be no less than 80th percentile of billed charges for that service. If we are unable to obtain sufficient data from a given geographical area, we will use a wider geographical area. If inclusion of the wider geographical area still does not provide sufficient data, we will set the allowed amount to no less than the equivalent of the 80th percentile or no lower than 250% of Medicare allowed amounts for the same services or supplies, whichever is greater.

  Services and Supplies from Professional Vision Care Providers: The allowed amount will be no less than the 80th percentile of billed charges as determined from a profile derived using the methodology described above.

- **For Services, Supplies Received Outside Our Service Area:**

  The allowed amount will be no less than the 80th percentile of billed charges in the geographical area in which a vision service or supply is received.

We reserve the right to determine the amount allowed for any given service or supply unless otherwise specified in the Group's administrative services agreement with us.

Calendar Year

The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on the next December 31 at midnight.

Copay

A fixed, up-front dollar amount that you're required to pay for certain covered services. Your vision care provider may ask that you pay this amount at the time of service. The copay amount doesn't vary with the cost of the services and doesn't apply toward applicable calendar year deductibles or out-of-pocket maximums.

Cost-share

Member's share of the allowed amount for covered services. Deductibles, copays, and coinsurance are all types of cost-shares. See the ***Summary of Your Benefits*** to find out what your cost-share is.

Effective Date

The date when your coverage under this vision plan begins. If you re-enroll in this vision plan after a lapse in coverage, the date that the coverage begins again will be your effective date.

Eligibility Waiting Period

The length of time that must pass before a subscriber or dependent is eligible to be covered under the health care plan. If a subscriber or dependent enrolls under the "Special Enrollment" provisions of this vision plan or enrolls on a date other than when first eligible to enroll, any period prior to such enrollment isn't considered an eligibility waiting period, unless all or part of the initial eligibility waiting period had not been met.

Enrollment Date

For the subscriber and eligible dependents who enroll when the subscriber is first eligible, the enrollment date is the subscriber's date of hire. There's one exception to this rule. If the subscriber was hired into a class of employees to which the Group doesn't provide coverage under this vision plan, but was later transferred to a class of employees to which the group does provide coverage under this vision plan, the enrollment date is the date the subscriber enters the eligible class of employees. (For example, the enrollment date for a seasonal employee who was made permanent after six months would be the date the employee started work as a permanent employee.). For subscribers who don't enroll when first eligible and for dependents added after the subscriber's coverage starts, the enrollment date is the effective date of coverage.

Experimental/Investigational Services

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria:

- A drug or device that can't be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn't been granted such approval on the date the service is provided.
- The service is subject to oversight by an Institutional Review Board.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence includes but isn't limited to reports and articles published in authoritative peer reviewed medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).

Group

The entity that sponsors this self-funded plan.

In-Network Vision Care Provider

A provider that is in one of the networks stated in the ***How Does Selecting A Vision Care Provider Affect My Benefits?*** section.

Medically Necessary

Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member (also called "You" or "Your")

A person covered under this vision plan as an employee or dependent.

Network Vision Care Provider

A vision care provider that is in one of the networks stated in the ***How Does Selecting A Vision Care Provider Affect My Benefits?*** section.

Out-of-Network or Non-Network Vision Care Provider

A vision care provider that is not in one of the provider networks stated in the ***How Does Selecting A Vision Care Provider Affect My Benefits?*** section.

Plan (also called "This vision plan" or "The Plan")

The Group's self-funded plan described in this booklet.

Service Area

The area in which we directly operate provider networks. This area is made up of the state of Alaska and the state of Washington (except for Clark County).

Subscriber

An enrolled employee of the Group. Coverage under this vision plan is established in the subscriber's name.

Subscription Charges

The monthly rates to be paid by the member that are set by the Group as a condition of the member's coverage under the vision plan.

Vision Care Provider

A vision care practitioner who is licensed as an ophthalmologist, optometrist or optician to practice health care related services consistent with state law, and that practices within the scope of such licensure or certification.

Such persons are considered health care providers only to the extent required by law and only to the extent services are covered by the provisions of this vision plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of his or her employment.

- Ocularists
- Opticians (Dispensing)
- Optometrists (OD)

Vision Plan (also called "This Plan" or "The Plan")

The benefits, terms and limitations set forth in this booklet.

We, Us And Our

Means Premera Blue Cross Blue Shield of Alaska.

where to send claims

MAIL YOUR CLAIMS TO:

Premera Blue Cross Blue Shield of Alaska
PO Box 91059
Seattle, WA 98111-9159

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www.premera.com