Vision Plan

4020427

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

HOW TO CONTACT THE CLAIMS ADMINISTRATOR

Please call or write Premera Blue Cross Blue Shield of Alaska's Customer Service staff for help with the following:

- Questions about the benefits of this vision plan
- Questions about your vision claims
- Questions or complaints about vision care or services you receive
- Change of address or other personal information

CUSTOMER SERVICE

Mailing Address:

Premera Blue Cross Blue Shield of Alaska
For Claims Only
P.O. Box 91059
Seattle, WA 98111-9159

Physical Address

3800 Centerpoint Dr., Suite 940
Anchorage, AK 99503

Telephone Numbers:

Local and toll-free number: 1-800-508-4722 (TTY: 711)

BLUECARD

1-800-810-BLUE(2583)

Online information about your vision plan is at your fingertips whenever you need it

You'll find answers to most of your questions about this vision plan in this benefit booklet. You also can explore our website at **premera.com** anytime you want to:

- Learn more about how to use this vision plan
- Locate an in-network vision care provider.
- Get details about the types of expenses you're responsible for and this vision plan's benefit maximums
- Check the status of your vision claims

Please go to **www.premera.com/ak/sbc** for your Notice of Protection provided by the Alaska Life and Health Insurance Guaranty Association.

You also can call our Customer Service staff at the numbers listed above. We're happy to answer your questions and appreciate any comments you want to share. In addition, you can get benefit, eligibility and claim information through our Interactive Voice Response system when you call Customer Service.

Group Name:	Kodiak Island Borough School District
Effective Date:	September 1, 2020
Group Number:	4020427
Plan:	Alaska LG NGF Stand-Alone Vision Plan
Certificate Form Number:	40204270920VP

Discrimination is Against the Law

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

Premera:

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

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross Blue Shield of Alaska. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-508-4722 (TTY: 800-842-5357).

አማሪኛ (Amharic):
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross Blue Shield of Alaska ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በእከፋፈል እርዳታ ለማኖኖት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት።በስልክ ቁጥር 800-508-4722 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):
يحوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross Blue Shield of Alaska. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ800-508-4722 (TTY: 800-842-5357)

中文 (Chinese):
本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross Blue Shield of Alaska 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-508-4722 (TTY: 800-842-5357)。

Oromoo (Cushite):
Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Premera Blue Cross Blue Shield of Alaska tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-508-4722 (TTY: 800-842-5357) tii bilbilaa.

Français (French):
Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross Blue Shield of Alaska. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-508-4722 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):
Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross Blue Shield of Alaska. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-508-4722 (TTY: 800-842-5357).

Deutsche (German):
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross Blue Shield of Alaska. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-508-4722 (TTY: 800-842-5357).

Hmoob (Hmong):
Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross Blue Shield of Alaska. Tej zaum muaj cov hnub tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-508-4722 (TTY: 800-842-5357).

Iloko (Ilocano):
Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti apliksayonyo wenno coverage babaen iti Premera Blue Cross Blue Shield of Alaska. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-508-4722 (TTY: 800-842-5357).

Italiano (Italian):
Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross Blue Shield of Alaska. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-508-4722 (TTY: 800-842-5357).

日本語 (Japanese):
この通知には重要な情報が含まれています。この通知には、Premera Blue Cross Blue Shield of Alaska の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-508-4722 (TTY: 800-842-5357)までお電話ください。

한국어 (Korean):
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross Blue Shield of Alaska 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-508-4722 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):
ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross Blue Shield of Alaska. ອາດຈະມີວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳໜົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-508-4722 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់ៗ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បៃបបទ ឬការរ៉ាប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross Blue Shield of Alaska ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាពដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការគ្រាងារ៉ាប់រងសុខភាពរបស់អ្នក ឬជ្រាកំជនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-508-4722 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):
ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross Blue Shield of Alaska ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-508-4722 (TTY: 800-842-5357).

فارسی (Farsi):
این اعلامیه حاوی اطلاعات مهم میباشد. این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق Premera Blue Cross Blue Shield of Alaska باشد. به تاریخ های مهم در این اعلامیه توجه نمایید. شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید. شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-508-4722 (کاربران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):
To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross Blue Shield of Alaska. Prosimy zwrócic uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-508-4722 (TTY: 800-842-5357).

Português (Portuguese):
Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross Blue Shield of Alaska. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-508-4722 (TTY: 800-842-5357).

Română (Romanian):
Prezenta notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin Premera Blue Cross Blue Shield of Alaska. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-508-4722 (TTY: 800-842-5357).

Русский (Russian):
Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross Blue Shield of Alaska. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-508-4722 (TTY: 800-842-5357).

Fa'asamoa (Samoan):
Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross Blue Shield of Alaska, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'amatalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-508-4722 (TTY: 800-842-5357).

Español (Spanish):
Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross Blue Shield of Alaska. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-508-4722 (TTY: 800-842-5357).

Tagalog (Tagalog):
Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross Blue Shield of Alaska. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-508-4722 (TTY: 800-842-5357).

ไทย (Thai):
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross Blue Shield of Alaska และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-508-4722 (TTY: 800-842-5357)

Український (Ukrainian):
Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross Blue Shield of Alaska. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-508-4722 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross Blue Shield of Alaska. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì báo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-508-4722 (TTY: 800-842-5357).

INTRODUCTION

This booklet is for members of the Kodiak Island Borough School District vision plan. This vision plan is self-funded by Kodiak Island Borough School District , which means that Kodiak Island Borough School District is financially responsible for the payment of vision plan benefits. Kodiak Island Borough School District ("the Group") has the final discretionary authority to determine eligibility for benefits and construe the terms of the vision plan.

Kodiak Island Borough School District has contracted with Premera Blue Cross Blue Shield of Alaska, an independent licensee of the Blue Cross Blue Shield Association, to perform administrative duties under the vision plan, including the processing of vision claims. Kodiak Island Borough School District has delegated to Premera Blue Cross Blue Shield of Alaska the discretionary authority to determine eligibility for benefits and to construe the terms used in this vision plan to the extent needed to perform our duties. Premera Blue Cross Blue Shield of Alaska does not insure the benefits of this vision plan. In this booklet, Premera Blue Cross Blue Shield of Alaska is called the "Claims Administrator." The terms "we," "us," and "our" also refer to Premera Blue Cross Blue Shield of Alaska. This booklet replaces any other benefit booklet you may have.

HOW TO USE THIS BOOKLET

This booklet will help you get the most out of your benefits. Every section contains important information, but the ones below may be particularly useful:

- **HOW TO CONTACT THE CLAIMS ADMINISTRATOR** – our website address, phone numbers, mailing addresses and other contact information are conveniently located inside the front cover
- **SUMMARY OF YOUR COSTS** – A quick overview of what the vision plan covers and your costs
- **HOW DOES SELECTING A VISION CARE PROVIDER AFFECT MY BENEFITS?** – how using in-network vision care providers will affect this vision plan's benefits and reduce your out-of-pocket costs
- **WHAT DO I NEED TO KNOW BEFORE I GET VISION CARE?** – the types of expenses you must pay for covered vision services
- **COVERED SERVICES** – what's covered under this vision plan
- **EXCLUSIONS** – services that are either limited or not covered under this vision plan
- **WHO IS ELIGIBLE FOR COVERAGE?** – eligibility requirements for this vision plan
- **HOW DO I FILE A VISION CLAIM?** – step-by-step instructions for vision claims submissions
- **COMPLAINTS AND APPEALS** – processes to follow to file a complaint or submit an appeal
- **DEFINITIONS** – many terms that have specific meanings under this vision plan. Example: The terms "you" and "your" refer to members under this vision plan.

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SUMMARY OF YOUR COSTS

This is a summary of your costs 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 vision care providers that do not have agreements with us, you are responsible for any amounts over the allowable charge.
- The **coinsurance**. This is a defined percentage of allowable charges 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 care provider 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		
Vision Exams This benefit provides one routine vision exam per member every calendar year	$20 copay	
Vision Hardware The plan pays allowable charges including any applicable sales tax, shipping and handling costs up to a maximum benefit shown below. Covered supplies include: • 1 pair of lenses or contact lenses per calendar year per member 1 frame every 2 consecutive calendar years per member up to $165.	$20 copay	

HOW DOES SELECTING A VISION CARE PROVIDER AFFECT MY BENEFITS?

The benefits of this vision plan are based on allowable charges for covered vision services and supplies. See ***Definitions*** for a definition of "allowable charge."

This vision plan does not require use or selection of a primary care provider or require referrals for vision care. Members may self-refer to vision care providers without pre-approval.

Benefits are provided under this vision plan for covered vision services from any licensed or certified vision care provider rendering services under the scope of their license. To help you manage the cost of vision care, the Group has made use of our provider network.

This vision plan's benefits are designed to provide lower out-of-pocket expenses when you receive care from in-network vision care providers.

In-Network Vision Care Providers

In-network vision care providers are providers that are part of our network in Alaska, any provider that has signed a contract with Blue Cross Blue Shield of Alaska, or a Host Blue's provider network. These vision care providers provide vision services at a negotiated fee. This fee is the allowed amount for in-network vision care providers.

Out-of-Network Vision Care Providers

Out-of-network vision care providers are providers that are not part of your provider network. These vision care providers may bill you for charges above the allowed amount. You may also be required to submit the vision claim yourself. See ***Sending Us a Vision Claim*** for details.

Finding an In-Network Vision Care Provider

A list of in-network vision care providers is available in our network provider directory. These vision care providers are listed by geographical area, specialty and in alphabetical order to help you select a vision care provider that is right for you.

We update this directory regularly and it is subject to change. We suggest that you call us for current information and to verify that your vision care provider, their office location or vision care provider group is included in the network before you get services.

The network provider directory is available any time on our website at **premera.com**. You may also request a copy of this directory by calling Customer Service at the number located on the inside front cover of this benefit booklet or on your Premera ID card.

VISION CARE PROVIDER STATUS

Since a vision care provider's agreement with us is subject to change at any time, it's important to verify a vision care provider's in or out-of-network status. This may help you avoid additional out-of-pocket expenses. Please call our Customer Service Department at the number listed inside the front cover of this booklet to verify a vision care provider's status. If you're outside Alaska and Washington or in Clark County, Washington, call 1-800-810-BLUE (2583) to locate or verify the status of a provider.

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 Costs*** for any vision deductible, copays (if any), coinsurance and benefit limits.

COPAYS AND COINSURANCE

A "copay" is a fixed up-front dollar amount that you're required to pay for each occurrence of certain covered vision services. Your vision care provider may ask you to pay the copay at the time of service.

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

What Doesn't Apply To The Calendar Year Deductible?

The calendar year deductible needn't be met before some benefits of this vision plan can be provided. These exceptions are stated in the specific benefits shown on the ***Summary of Your Costs***.

Other amounts that don't accrue toward this vision plan's calendar year deductible are:

- Amounts that exceed the allowable charge
- Charges for excluded services

COVERED SERVICES

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

Vision Benefits

Benefits are available for covered vision services and supplies when they meet all of the following requirements.

- It must be medically necessary and must be furnished in a medically necessary setting
- It must be named in this benefit as covered
- It must not be excluded from coverage under this vision plan
- The expense for it must be incurred while you're covered under this vision plan.
- It must be furnished by a vision care provider who is performing services within the scope of his or her license or certification.

Benefits for some types of vision services and supplies may be limited or excluded under this vision plan. Please refer to the actual benefit provisions below and the ***Exclusions*** section for a complete description of covered vision services and supplies, limitations and exclusions.

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

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.

The following types of vision hardware are covered under this benefit:

- 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

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; and
- Case history and recommendations.

Benefits for vision hardware 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.

Covered supplies include:

- Lenses
- Contact lenses
- Frames

The following types of vision hardware are also covered under this benefit.

- Progressive lenses
- Anti-reflective coating
- Scratch resistant coating
- Polycarbonate lenses
- Prescription eyeglass lenses (single vision, bifocal, trifocal, quadrafocal or lenticular)
- Prescription safety glasses
- Prescription sunglasses
- Fitting of eyeglass lenses to frames
- Fitting of contact lenses to the eyes

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

Vision hardware benefits are based on allowable charges for covered services and supplies. See the ***Definitions*** section for a definition of "allowable charge." Charges for vision services or supplies that exceed what's covered under this benefit aren't covered under other benefits of this vision plan.

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.

WHAT DO I DO IF I'M OUTSIDE ALASKA AND WASHINGTON?

OUT-OF-AREA CARE

As a member of the Blue Cross Blue Shield Association ("BCBSA"), Premera Blue Cross Blue Shield of Alaska has arrangements with other Blue Cross and Blue Shield Licensees ("Host Blues") for care outside our Service Area. These arrangements are called "Inter-Plan Arrangements." Our Inter-Plan Arrangements help you get covered services from providers within the geographic area of a Host Blue.

The BlueCard® Program is the Inter-Plan Arrangement that applies to most claims from Host Blues' network providers. The Host Blue is responsible for its network providers and handles all interactions with them. Other Inter-Plan Arrangements apply to providers that are not in the Host Blues' networks (out-of-network providers). This Out-Of-Area Care section explains how the plan pays both types of providers.

Your getting services through these Inter-Plan Arrangements does not change covered benefit levels, or any stated eligibility requirements. Please call us if your care needs prior authorization.

BlueCard Program

Except for copays, we will base the amount you must pay for claims from Host Blues' network providers on the lower of:

- The provider's billed charges for your covered services; or
- The allowable charge that the Host Blue made available to us. See ***Definitions*** for a definition of "allowable charge."

Often, the allowable charge is a discount that reflects an actual price that the Host Blue pays to the provider. Sometimes it is an estimated price that takes into account a special arrangement with a single provider or a group of providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of providers.

Host Blues may use a number of factors to set estimated or average prices. These may include settlements, incentive payments, and other credits or charges. Host Blues may also need to adjust their prices to correct their estimates of past prices. However, we will not apply any further adjustments to the price of a claim that has already been paid.

Clark County Providers Services in Clark County, Washington are processed through the BlueCard Program. Some providers in Clark County do have contracts with us. These providers will submit claims directly to us, and benefits will be based on our allowable charge for the covered service or supply.

Taxes, Surcharges and Fees

A law or regulation may require a surcharge, tax or other fee be added to the price of a covered service. If that happens, we will add that surcharge, tax or fee to the allowable charge for the claim.

Out-of-Network Providers

It could happen that you receive covered services from providers outside our service area that do not have a contract with the Host Blue. In most cases, we will base the amount you pay for such services on either our allowable charge for these providers or the pricing requirements under applicable law. See ***Definitions*** for a definition of "allowable charge."

In these situations, you may owe the difference between the amount that the out-of-network provider bills and the payment the plan makes for the covered services as set forth above.

Blue Cross Blue Shield Global® Core Program

If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands (the "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core. Blue Cross Blue Shield Global Core is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although Blue Cross Blue Shield Global Core helps you access a provider network, you will most likely have to pay the provider and send us the claim yourself in order for the plan to reimburse you. See ***How Do I File A Vision Claim?*** for more information on submitting claims.

If you need to find a vision care provider outside the BlueCard service area, need help submitting claims or have other questions, please call the service center at 1-800-810-BLUE (2583). The center is open 24 hours a day, seven days a week. You can also call collect at 1-804-673-1177.

Further Questions?

If you have questions or need to find out more about the BlueCard Program, please call our Customer Service Department. To find a provider outside our service area, go to **premera.com** or call 1-800-810-BLUE (2583). You can also get Blue Cross Blue Shield Global Core information by calling the toll-free phone number.

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 Allowable Charge

This vision plan does not cover amounts over the allowed amount as defined by this vision plan. If you get 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

Separate charges from providers for supplying records or reports.

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

The vision plan does not cover services, drugs, or supplies for cosmetic purposes, 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

This vision plan does not cover 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

Benefits are not provided under this vision plan for drugs or medication, including prescription or over-the counter drugs.

Environmental Therapy

This vision plan does not cover therapy to provide a changed or controlled environment.

Experimental and Investigational Services

This vision plan does not cover any service that is experimental or investigative, see ***Definitions***. This vision plan also does not cover any complications or effects of such services.

Family Members or Volunteers

This vision plan does not cover services that you give 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

This plan does not cover charges for services received as a result of an Injury, Illness and/or Sickness resulting from or occurring during the commission of a violation of law by the Plan Participant, including but not limited to, a felony, a misdemeanor, and/or engaging in an illegal occupation. This exclusion does not apply to minor traffic violations. The Plan Administrator has full discretion to determine what constitutes a minor traffic violation. Under no circumstances will operating a motor vehicle while under the influence of alcohol or drugs (illegal drugs and/or Prescription Drugs), or a combination thereof, or operating a motor vehicle with a blood alcohol content (BAC) above the legal limit, be considered a minor traffic violation. For this exclusion to apply, it is not necessary that a fine be imposed or criminal charges be filed, or if filed, that a conviction result or that a sentence be imposed. This exclusion does not apply if the Injury, Illness, and/or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

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

This vision plan does not cover 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

This vision plan does not cover 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
- Directly related to any condition, or related to any other service or supply, that is not covered
- 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

Not Medically Necessary

Services and places of service that are not medically necessary.

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 vision plan were not in effect, or for which you are not legally required to pay.

Terrorism

This vision plan does not cover illness or injury you get while committing an act of terrorism, or an act of riot or revolt.

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. Also not covered are treatment or surgeries to improve the refractive character of the cornea, including the treatment of any results of such treatment.

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.

If you have other coverage besides this vision plan, we recommend that you submit your vision claim to the primary carrier first, and then submit the vision 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 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 health care coverage

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 vision claim so that the benefits from all health plans aren't more than the allowable vision expense for that vision 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 health 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 vision 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 vision 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 vision plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this vision 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 vision 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 vision bills, the member must choose to put the benefit to use towards those vision bills before coverage under this vision 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 vision plan's vision benefits will be provided.

Reimbursement and Subrogation Rights

If the plan advances payment of benefits to you for an injury, the vision plan has the right to be repaid in full for those vision 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 vision plan shall also be entitled to reimbursement by asking for refunds from providers for the vision claims that it had already paid.
- The vision 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 vision 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 vision 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 vision plan has the right to be repaid, the vision 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 vision plan can file its own lawsuit against a responsible third party. If this happens, you must co-operate with the vision plan as it pursues its claim.

  The vision 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 vision plan.

Your Responsibilities

- If any of the requirements below are not met, the vision plan shall:
  - Deny or delay vision claims related to your injury
  - Recoup directly from you all benefits the vision plan has provided for your injury
  - Deduct the benefits owed from any future vision 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 vision plan's rights under this provision.
- You must cooperate fully with the plan in the recovery of the vision benefits advanced by the vision plan and the vision plan's exercise of its reimbursement and subrogation rights. You must take no action that would prejudice the vision 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 vision plan an Incident Questionnaire and any other documents required by the vision 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 vision plan will not pay any more vision claims for the injury unless you and the plan agree otherwise.
- You must notify the vision 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 vision plan's reimbursement rights have been satisfied. The vision 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 vision plan out of the recovery proceeds.

If you or your lawyer do not promptly set the recovery funds apart and reimburse the vision 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 vision 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 vision plan.

WHO IS ELIGIBLE FOR COVERAGE?

This section of your booklet describes who is eligible for vision coverage.

Please note that you do not have to be a citizen of or live in the United States if you are otherwise eligible for vision coverage.

SUBSCRIBER ELIGIBILITY

Under this large employer vision benefit plan, to be an "eligible employee," an employee must be one of the following:

Administrators

The employee must also:

- Regularly work a minimum of 30 hours per week
- Complete a 30-day probationary period

Exempt

The employee must also:

- Regularly work a minimum of 30 hours per week
- Complete a 30-day probationary period

Classified

The employee must also:

- Regularly work a minimum of 30 hours per week
- Complete a 60-day probationary period (eligibility will be first of the month following the completed 60-day probationary period)

Certificated

The employee must also:

- Regularly work a minimum of 30 hours per week
- Complete a 30-day probationary period

An active employee is an employee who is on the regular payroll role of the employer and who has begun to perform the duties of his or her job with the employer full time or part time.

An Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

An Employee is considered to be Part-Time if he or she normally works at least 15 hours per week and is on the regular payroll of the Employer for that work.

Employees Performing Employment Services in Hawaii

For employers other than political subdivisions, such as state and local governments, and public schools and universities, the State of Hawaii requires that benefits for employees living and working in Hawaii (regardless of where the Group is located) be administered according to Hawaii law. If the Group is not a governmental employer as described in this paragraph, employees who reside and perform any employment services for the Group in Hawaii are not eligible for coverage. When an employee moves to Hawaii and begins performing employment services for the Group there, he or she will no longer be eligible for coverage.

DEPENDENT ELIGIBILITY

An “eligible dependent” is defined as one of the following:

- The lawful spouse of the subscriber, 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 vision plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this vision 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 who is under 26 years of age. An eligible child is one of the following:
  - A natural offspring of either or both the subscriber or spouse;
  - A legally adopted child of either or both the subscriber or spouse;
  - A child "placed" with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child;
  - A minor or foster child for whom the subscriber or spouse has a legal guardianship. There must be a court order or other order signed by a judge or state agency, 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.

Grandchildren aren’t eligible for coverage.

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

Enrollment is timely when we receive the completed enrollment application and required subscription charges within 60 days of the date the employee becomes an "eligible employee" as defined earlier in this section. When enrollment is timely, coverage for the employee and enrolled dependents will become effective on the first of the month that coincides with or next follows the **latest** of the applicable dates below:

- The employee's date of hire;
- The date the employee enters a class of employees to which the Group offers coverage under this vision plan;
- The next day following the date the probationary period ends, if one is required by the Group

If we don’t receive the enrollment application within 60 days of the date you became eligible, none of the dates above will apply. See ***Open Enrollment*** and ***Special Enrollment*** below.

Dependents Acquired Through Marriage After The Subscriber's Effective Date

When we receive the completed enrollment application and any required subscription charges within 60 days after the marriage, coverage will become effective on the first of the month following the date of marriage. When the enrollment application isn’t received by us within 60 days of marriage, refer to ***Open Enrollment*** later in this section.

Newborn And Adoptive Children

Natural newborn dependent children of the subscriber born on or after the subscriber’s effective date will be covered from their date of birth. However, if payment of additional subscription charges is required to provide coverage for a newborn child, and the subscriber desires coverage of the newborn child to extend beyond the 31-day period following the newborn child’s date of birth, we must receive a completed enrollment application and the required additional subscription charges within the 90-day period following the date of birth.

Adoptive dependent children of the subscriber who are adopted or placed for adoption on or after the subscriber's effective date will be covered from their date of adoption or placement for adoption. However, if payment of additional subscription charges is required to provide coverage for an adoptive dependent child, and the subscriber desires coverage of the adoptive child to extend beyond the 31-day period following the dependent child's date of adoption or placement for adoption, we must receive a completed enrollment application and the required additional subscription charges within the 90-day period following the date of adoption or placement for adoption.

If we don't receive the completed enrollment application and the required additional subscription charges within the 90-day period, initial coverage will be limited to the 31-day period referenced above. The child may then be enrolled at a later date, subject to the ***Open Enrollment*** provisions described later in this section.

Children Acquired Through Legal Guardianship

When we receive the completed enrollment application, any required subscription charges, and a copy of the guardianship papers within 60 days of the date legal guardianship began with the subscriber, coverage for an otherwise eligible child will begin on the date legal guardianship began. When the enrollment application isn't received by us within 60 days of the date legal guardianship began, refer to ***Open Enrollment*** below.

Children Covered Under Medical Child Support Orders

When we receive the completed enrollment application within 60 days of the date of the medical child support order, coverage for an otherwise eligible child that is required under the order will become effective on the date of the order. Otherwise, coverage will become effective on the date we receive the enrollment application for coverage. The enrollment application may be submitted by the subscriber, the child's custodial parent or a state agency. When subscription charges being paid don't already include coverage for dependent children, such charges will begin from the child's effective date. Please contact your Group for detailed procedures.

Court-Ordered Dependent Coverage

When we receive the completed enrollment application within 60 days of the date of the court order, coverage for a lawful spouse and/or dependent children 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 enrollment application for coverage. When subscription charges being paid don't already include coverage for a spouse and/or dependent children, such charges will begin from the dependent's effective date.

SPECIAL ENROLLMENT

Involuntary Loss Of Other Coverage

If an employee and/or dependent doesn't enroll in this vision 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 vision 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 vision 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 vision 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 vision 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. 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 vision 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.

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 set by the Group. During this period, eligible employees and their dependents can enroll for coverage under this vision plan.

If the Group offers multiple health care plans and you're enrolled under one of the Group's other health care plans, enrollment for coverage under this vision plan can only be made during the Group's open enrollment period.

Please note: Open enrollment begins on November 15th and ends on December 15th each calendar year.

CHANGES IN COVERAGE

No rights are vested under this vision plan. The Group may change its terms, benefits, and limitations at any time. Changes to this vision 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 vision plan after the date the change becomes effective.

PLAN TRANSFERS

Subscribers (with their enrolled dependents) may be allowed to transfer to this vision plan from another plan offered by the Group. Transfers also occur if the Group replaces another plan with this vision plan. All transfers to this vision plan must occur during open enrollment or on another date set by the Group.

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

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

Coverage will end without notice on the last day of the month in 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
- 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

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

PLAN TERMINATION

No rights are vested under this vision plan. The Group is not required to keep the vision plan in force for any length of time. The Group reserves the right to change or terminate this vision plan, in whole or in part, at any time with no liability. Vision 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 vision 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.

LEAVE OF ABSENCE

Coverage for a subscriber and enrolled dependents may be continued for up to 90 days, or as otherwise required by law, when the employer 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.

REHIRING A TERMINATED EMPLOYEE

A terminated Employee who is rehired prior to the end of a 26 consecutive week period after the date of termination will be credited with time met towards the employment Waiting Period as of the date of termination. Coverage will be reinstated the first day of the first calendar month following the date of rehire or the first day of the first calendar month following completion of the Waiting Period. Employees rehired after a break in service of 26 consecutive weeks or more will be treated as a new hire.

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 vision 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 domestic partners and their children have the same rights to COBRA coverage as covered spouses and their children.

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.

- 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 vision plan. The extended period will end no later than 36 months from the date of the first 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 vision 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 the ***When COBRA Coverage Ends*** section for details.

- 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're 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.

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 vision 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, or child's loss of eligibility as a dependent.

If the required notice is not given or is late, the qualified member loses the right to COBRA coverage. The subscriber or affected dependent has 60 days in which to give notice to the Group. 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're 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 loss of retiree coverage because the Group filed for bankruptcy. The plan administrator then has 14 days after it receives notice of a qualifying event from a qualified member as stated above or from the Group 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 loss of retiree coverage because the Group filed for bankruptcy 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.

  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 the ***Qualifying Events And Lengths Of Coverage*** section 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 vision 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 (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 vision 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.

OTHER CONTINUED COVERAGE OPTIONS

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 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 website at **www.dol.gov/vets**. An online guide to USERRA can be viewed at **www.dol.gov/elaws/userra.htm**.

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, 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 plan won't provide benefits for claims we receive after the later of these two dates, nor will the plan provide benefits for 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 provider who submitted the vision claim that we need more information. We will make that request within 30 days of receipt.
- 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 vision care provider requires a copay when you get vision services or supplies, it is not considered a vision 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 vision 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 claims information. To file a vision claim, please see the ***How Do I File A Vision Claim?*** section for more detail. If your vision claim is denied in whole or in part, you may submit a complaint or appeal as outlined under ***Complaints and Appeals*** in this booklet.

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 vision services or supplies received; the names and credentials of the treating providers.

To process your foreign claim, we will convert the foreign currency amount on the claim into US dollars for claims processing. We use a national currency converter (available at **www.oanda.com**) as follows:

- For professional outpatient services and other care with single dates of service, we use the exchange rate on the date of service
- For inpatient stays of more than one day, we use the exchange rate on the date of discharge

COMPLAINTS AND APPEALS

We know healthcare doesn't always work perfectly. Our goal is to listen, take care of you, and make it simple. If it does not go the way you expect, you have two options:

- Complaints – you can contact customer service if you have a complaint, we may ask you to send the details in writing. We will send a written response within 30 days.
- Appeals – is a request to review specific decisions we have made

You can appeal the following adverse benefit determinations (see ***Definitions)****:*

- Benefits or charges were not applied correctly
- A decision regarding your eligibility to enroll or stay in the plan, including rescissions
- A decision by the plan that services were experimental, investigative, or not medically necessary

HOW TO SUBMIT AN APPEAL

After you are notified of an adverse benefit determination, you can request an internal appeal. Your plan includes two levels of internal appeals.

- **Level I internal appeal** People who were not part of the initial decision will review your appeal. Medical review denials will be reviewed by a medical specialist. We must receive your internal appeal request within 180 days of the date you were notified of our initial decision. You can request an extension of the 180-day deadline by sending us a written request that includes the reason why you believe an extension should be granted.

- **Level II internal appeal** within 60 calendar days of the date you are notified of the Level I determination. If you are hospitalized or traveling; or for other reasonable cause beyond your control, we will extend this timeline up to 180 calendar days to allow you to obtain additional medical documentation, physician consultations or opinions.

  The Level II internal appeal will be reviewed by a panel of people who were not part of the Level I internal appeal. Medical review denials will be reviewed by a medical specialist. You may take part in the level II panel meeting in person or by phone. Please call us for more details about this process. Once the Level II review is complete, we will provide you with a written determination. If you are not satisfied with the final internal appeal decision, you may be eligible to request an ***External Appeal***, as described below.

WHO CAN APPEAL?

You can appeal yourself or choose someone, including your doctor, to appeal on your behalf. If you choose someone else, complete an Authorization for Appeals form located on **premera.com**. We can't release your information without this form.

HOW TO APPEAL

You can call Customer Service, or you can write to us at the address listed inside the front cover of this book. By sending your appeal in writing, you can provide more details about 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 need help filing an appeal, or would like a copy of the appeals process, please call Customer Service. You can also get a description of the appeals process by visiting our website.

If you would like to review the information used for your appeal, please contact Customer Service. The information will be sent as soon as possible and free of charge.

WHAT HAPPENS WHEN YOU HAVE ONGOING CARE

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 HAPPENS WHEN IT'S URGENT

If your condition is urgent, we will handle your appeal in an expedited (fast) manner. Examples of urgent situation are:

- Your life or health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal
- You are inpatient or receiving emergency care

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

Urgent appeals are only available for services you are currently receiving or have not yet received.

WHAT HAPPENS NEXT

Your appeal is reviewed, and a decision is provided within the time limits below

Type of appeal	**When to expect notification of a decision**
Expedited appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing.
Other Appeals	Within 30 days

If we stand by our first decision or we do not follow the process above, you can request an external appeal. External appeal is 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.

EXTERNAL APPEAL External review will be done by an Independent Review Organization (IRO). An IRO is an independent organization of medical reviewers who are qualified to review medical and other relevant information. There is no cost to you for an external review.

- We will send you an external review request form at the end of the internal appeal process notifying you of your rights to an external review
- We must receive your written request for an external review within 4 months of the date you received the final internal adverse benefit determination. You must include the signed external appeal form you received from us. You may also include medical records and other information.
- We will forward your medical records and other information to the IRO. If you have additional information on your appeal, we will tell you how to send it to the IRO.

WHAT HAPPENS NEXT

Once the external appeal is done, the IRO will let you and the plan know their decision within the time limits below.

- For urgent external appeals no later than 72 hours after receiving the request
- For all other appeals, within 45 days from the date the IRO gets your request.

ONCE A DECISION IS MADE

For urgent appeals, the IRO will inform you and the plan immediately. We will follow up with a written decision by mail. For all other appeals, we will send you a written decision by mail.

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.

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 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 vision 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.

Intentionally False Or Misleading Statements

If this vision plan's benefits are paid in error due to any intentionally false or misleading statements, the 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 claim;

- Reduce the amount of benefits provided for your claim; or
- Void your coverage under this vision plan. (Void means to cancel coverage back to its effective date as if it had never existed at all.) Your 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 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 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 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 plan, we have the right to recover amounts the 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 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 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 plan's obligation as to payment of benefits.

Venue

All suits and legal proceedings, including arbitration proceedings, brought against us, the 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

Allowable Charge

The allowable charge 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 allowable charge is the lesser of the following:

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

  Contracting 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, allowable charges 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 allowable charge for Alaska or Washington providers that don't have a contract with us is the least of the three amounts shown below. The allowable charge for providers outside Alaska or Washington that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below.

  - An amount that is no less than the lowest amount the plan allows for the same or similar service from a comparable provider that has a contracting agreement with us
  - 200% 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 allowable charge than the least of the three amounts above, this plan will comply with that law.

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

  The allowable charge for Alaska or Washington providers that don't have a contract with us is the least of the three amounts shown below. The allowable charge for providers outside Alaska or Washington that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below.

  - An amount that is no less than the lowest amount the plan allows 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 allowable charge than the least of the three amounts above, this plan will comply with that law.

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 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.

Cost-share

Member's share of the allowable charge for covered services. Deductibles, copays, and coinsurance are all types of cost-shares. Please see the ***Summary of Your Costs*** 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
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- 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.

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 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 (O.D.)

Vision Plan (also called "This Vision 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.