Everything you need to know about your vision plan

Independence

Independence

Vision

The clear solution to your vision care needs

Use your vision benefits

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

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

View your benefits online

Visit

Ibx.com

Freedom of provider choice

You have access to the Davis Vision provider network, which includes more than 84,000 points of access.

Choose from an extensive frame collection

You can select any frame from the Davis Vision Exclusive Frame Collection of stylish, contemporary frames covered in full, or with a minimal copay. You also have the freedom to use your frame allowance at any network location toward any frame on the market today.

Accidents happen and they are covered. All glasses provided by Davis Vision laboratories are warranted against breakage for one year from the original date of dispensing.

Coverage for contacts and laser vision correction

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

You can also view your benefits online through **ibx.com**. You can:

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

DavisVision™

Visionworks retail centers offer affordability, choice, and convenience

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

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

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

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

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

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

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

Vision Benefits Program

Form No. 5046-BC
Rev. 1.20

Group Number:10103618

QCC INSURANCE COMPANY
(Hereafter called "The Health Benefit Plan")

Group (Contractholder)
(Hereafter called "The Contractholder")

VISION CARE PROGRAM

QCC Insurance Company
(Hereafter called "the Health Benefit Plan")

Group Health Benefits
Benefit Booklet

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

This Benefit Booklet replaces any and all Benefit Booklets previously issued by the Health Benefit Plan providing the types of benefits described in this Benefit Booklet.

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

QCC INSURANCE COMPANY

Paula Sunshine
SVP and Chief Marketing Executive

ATTEST:

Jonathan Stump
VP Product Services

Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Discrimination is Against the Law

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

This Plan provides:

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

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

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

VISION CARE COVERAGE

TABLE OF CONTENTS

SECTION 1 – SCHEDULE OF BENEFITS

VISION CARE BENEFITS

Subject to the Exclusions, conditions and Limitations of this Benefit Booklet, a Member is entitled to benefits for Covered Services described in this section during a Benefit Period, and in the amounts as specified in this **Schedule of Benefits** section.

Benefit Period	One (1) Calendar Year
Coinsurance	None
Benefit Period Maximum (Participating or Non-Participating)	$75 for all Covered Services and Supplies; except eye examination services are not included in this Benefit Period Maximum.

SCHEDULE OF COVERED SERVICES

COVERED SERVICES	AMOUNTS PAYABLE AND LIMITATIONS ON COVERED SERVICES	
	Participating*	**Non-Participating**
Eye examination, including refraction and glaucoma screening and dilation, as professionally indicated.	100% of the Provider's Reasonable Charge.	100% of the Provider's Reasonable Charge, up to a Maximum of $35.
Eyeglasses, including Spectacle Lenses and Frames (one pair).		100%, up to a Maximum of $75 for Eyeglasses, including Spectacle Lenses and Frames, or Contact Lenses.
Spectacle Lenses		
• All ranges of prescriptions, oversize lenses, glass or plastic, single vision, bifocal, trifocal or lenticular lenses	100%	
• Polycarbonate lenses for dependent children, monocular patients and patients with prescriptions greater than or equal to +/- 6.00 diopters	100%	
• Glass grey #3 prescription sunglass lenses	100%	
• Tinting	100%	
Frames - Plan supplied: • Fashion selection • Designer selection • Premier selection OR - Doctor supplied:	100%, with a Copayment of: $0 $0 $20 Up to a Maximum of $60 towards purchase	

Contact Lenses (in lieu of eyeglasses) including Standard, Specialty and Disposable Lenses and Evaluation and Fitting	100%, up to a Maximum of $75

Out-of-pocket expenses incurred by a Member for pediatric Vision Care benefits will be included in the calculation of the Member's overall medical plan out-of-pocket limit.

* The Health Benefit Plan reserves the right to modify the ***Schedule of Covered Services*** from time to time, subject to prior notice to the Group.

SECTION 2 – VISION CARE BENEFITS
COVERED SERVICES

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

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

A Member who receives Vision Care services from a Participating Provider can elect to utilize a Non-Participating Provider for related Vision Care services on the recommendation or referral of the Participating Provider, provided that the Participating Provider gives to the Member, prior to recommending, referring, prescribing or ordering any Vision Care services from the Non-Participating Provider, written notice that:

- The Non-Participating Provider is not a Participating Provider.
- The Member has the option of selecting a Participating Provider.
- The Member may have different financial obligations depending on whether the Vision Care Provider is Participating or Non-Participating.

Vision Care services received from a Non-Participating Provider are not covered under this Health Benefit Plan.

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

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

Professional Services

- Eye Examination Services
  Such services, performed by a Professional Provider, as defined in the section entitled ***Important Definitions*** shall include, but are not limited to:
  - Case history.
  - Visual acuity, near and far.
  - External examination, including biomicroscopy or other magnified evaluation of the anterior chamber.

- Objective, subjective and ophthalmoscopic examinations.
- Binocular measure.
- Summary, findings, and recommendations.

- Hardware
  - Contact Lens Prescription and Fitting Services
    Such services, performed by a Professional Provider shall include, but are not necessarily limited to:
    - Keratometry, or "K" reading, through the use of a keratometer to determine measurements of the eyes, curvature and base curve.
    - Proper fitting of appropriate contact lenses, including the training of insertion and removal of trial contact lenses to the Member's corneas.
    - Post-dispensing contact lens follow-up care, including correction of any ill-fitting or unsuitable lenses.

    Contact Lens Prescription and Fitting Services must be preceded by Eye Examination Services as described in the "Eye Examination Services" subsection shown above.
  - Post-Refractive Services
    Post-refractive Services consist of the ordering of lenses and frames (facial measurements, lenticular formula and other specifications), cost of the materials, verification of the completed prescription upon return from the laboratory, adjustment of the completed eyeglasses to the Member's face and the subsequent servicing (For Example, refitting, realigning, readjusting, tightening).

Limitations

- In cases involving Covered Services in which the Professional Provider or Supplier and Member elect to utilize photogrey or light sensitive lenses, the program may provide benefits providing the Member qualifies for such benefits. See the ***Schedule of Benefits*** for the benefit allowance, if any.
- Payment for frames, or spectacle lenses and/or contact lenses will be made only if prescribed by a Professional Provider or Supplier.

SECTION 3 - EXCLUSIONS - WHAT IS NOT COVERED

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

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

- For duplicate and temporary devices, appliances, and services. This exclusion does not apply to disposable contact lenses;

- For which the Member incurs no charge;

- In a facility performed by a Professional Provider or Supplier who in any case is compensated by the facility for similar Covered Services performed for patients;

- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan;

- For any loss sustained or expenses Incurred during military services while on active duty; or as a result of an act of war, whether declared or undeclared;

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

- For low vision aids;

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

SECTION 4 - WHO IS COVERED

Eligible Person

- Eligible Person is defined as a Member who is determined by the Contractholder as eligible to apply for coverage and sign the Application; and
- Eligible Dependents as specified to the Health Benefit Plan by the Contractholder as eligible for coverage.

Eligible Dependent

Eligible Dependent is defined as:

- The Member's spouse under a legally valid existing marriage between persons of the opposite sex.
- The unmarried children, including newborn children, step-children, children legally placed for adoption, and legally adopted children of the Member or the Member's spouse, or children for whom the Member is a legal guardian or newborns of dependent children covered under the Group Contract. The limiting age for covered, unmarried children is to the first of the month following the month in which they reach age 19-26; or if a student is enrolled full-time in an Accredited Educational Institution, the limiting age is the first of the month following the month in which they reach age 19-26.

  In addition, a full-time student will be considered eligible for coverage when they are on a Medically Necessary leave of absence from the Accredited Educational Institution. The Health Benefit Plan must receive certification from the full-time student's physician that the full-time student is suffering from a serious illness or injury that requires a Medically Necessary leave of absence from the Accredited Educational Institution or requires the full-time student to become a part-time student. The Dependent child will be eligible for coverage until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate. The limiting age referenced above will be applicable regardless of the status of the Medically Necessary leave of absence.
- A full-time student who is eligible for coverage under the coverage who is:
  - A member of the Pennsylvania National guard or any reserve component of the U.S. armed forces and who is called or ordered to active duty, other than active duty for training for a period of 30 or more consecutive days; or
  - A member of the Pennsylvania National Guard who is ordered to active state duty, including duty under Pa. C.S. Ch.76 (relates to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

  Eligibility for these Dependents will be extended for a period equal to the duration of the Dependent's service on duty or active state duty or until the individual is no longer a full-time student regardless of the age of the Dependent when the educational program at the Accredited Educational Institution was interrupted due to military duty.

  As proof of eligibility, the Employee must submit a form to the Health Benefit Plan approved by the Department of Military & Veterans Affairs (DMVA):
  - Notifying the Health Benefit Plan that the Dependent has been placed on active duty;
  - Notifying the Health Benefit Plan that the Dependent is no longer on active duty;
  - Showing that the Dependent has re-enrolled as a full-time student in an Accredited Educational Institution for the first term or semester starting 60 or more days after his release from active duty.

- Eligibility will be continued past the limiting age for unmarried children, regardless of age, who are incapable of self-support because of mental retardation or physical handicap, mental illness or developmental disability and who are dependent for support upon a Member covered under the Group Contract. The Health Benefit Plan may require proof of such Member's eligibility from time to time.
- The newborn child(ren) of a Member from the moment of birth to a maximum of 31 days immediately following birth. The coverage of newborn children within such 31 day period shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities and prematurity and services of a doctor rendered as part of nursery care, but not nursery charges. To continue coverage beyond the 31 day period, application for coverage must be made within 31 days of the child's birth and the appropriate premium paid.

Effective Date
The date the Contractholder agrees that all Eligible Persons may apply and become covered. If a person becomes an Eligible Person after the Health Benefit Plan's Effective Date, that date becomes the Effective Date.

SECTION 5 - GENERAL INFORMATION

Benefits To Which Members Are Entitled

- The liability of the Health Benefit Plan is limited to the benefits specified in the Group Contract.
- No person other than a Member is entitled to receive benefits under this Program.
- Benefits for Covered Services will be provided only for services and supplies that are rendered by a Professional Provider specified in the ***Important Definitions*** section of this Benefit Booklet.

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

When a Member ceases to be an Eligible Employee or Eligible Dependent, or the required contribution is not paid, the Member's coverage will terminate at the end of the last month for which payment was made. However, if benefits under this Program are provided by and/or approved by the Health Benefit Plan before the Health Benefit Plan receives notice of the Member's termination under this Program, the cost of such benefits will be the sole responsibility of the Member. In that circumstance, the Health Benefit Plan will consider the effective date of termination of a Member under this Program to be not more than 30 days before the first day of the month in which the Contractholder notified the Health Benefit Plan of such termination.

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

A Member's benefits under this Program may be extended after the date that person ceases to be a Member under the Group Contract because of termination of employment or termination of membership in the group. It will be extended if, on that date, the person is Totally Disabled from an illness or injury. The extension is only for that illness or injury and any related illness or injury. It will be for the time the person remains Totally Disabled from any such illness or injury, but not beyond 12 months if the person ceases to be a Member because the Group Contract ends.

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

When You Terminate Employment - Continuation Of Coverage Provisions - Consolidated Omnibus Budget Reconciliation Act Of 1985, As Amended (COBRA)

The Employee should contact their Employer for more information about COBRA and the events that may allow the Employee or the Employee's eligible Dependents to temporarily extend health care coverage.

When The Employee Terminates Employment - Continuation Of Coverage Provisions Pennsylvania Act 62 Of 2009 (Mini-COBRA)
This subsection, and the requirements of Mini-COBRA continuation, applies to groups consisting of two to 19 Employees.

For purposes of this subsection, “qualified beneficiary” means any person who, before any event which would qualify that person for continuation under this subsection, has been covered continuously for benefits under this Program or for similar benefits under any group policy which it replaced, during the entire three-month period ending with such termination as:

- A covered Employee;
- The Employee’s spouse; or
- The Employee’s Dependent child.

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

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

- If An Employee Terminates Employment or Has a Reduction of Work Hours: If the Employee's group benefits end due to the Employee's termination of employment or reduction of work hours, the Employee may be eligible to continue such benefits for up to nine months, if:
  - The Employee's termination of employment was not due to gross misconduct;
  - The Employee is not eligible for coverage under Medicare;
  - The Employee verifies that the Employee is not eligible for group health benefits as an eligible dependent; and
  - The Employee is not eligible for group health benefits with any other carrier.

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

- The Employer's Responsibilities: The Employee's employer must notify the Employee, the plan administrator, and the Health Benefit Plan, in writing, of:
  - The Employee's termination of employment (for reasons other than gross misconduct) or reduction of work hours;
  - The Employee's death;
  - The Employee's divorce or legal separation from an eligible dependent;
  - The Employee becomes eligible for benefits under Social Security;
  - The Employee's dependent child ceases to be a dependent child pursuant to the terms of the group health benefits Benefit Booklet;
  - Commencement of Employer's bankruptcy proceedings.

  The notice must be given to the Employee, the plan administrator and the Health Benefit Plan no later than 30 days of any of these events.

- The Qualified Beneficiary's Responsibilities: A person eligible for continuation under this subsection must notify, in writing, the administrator or its designee of their election of continuation coverage within 30 days of receipt of the Notice from the Employer.

  Continuation coverage shall be effective as of the date of the event.

  Upon receipt of the Employee's, or the Employee's eligible dependent's election of continuation coverage, the administrator, or its designee, shall notify the Health Benefit Plan of the election within 14 days.

- If an Employee Dies: If the covered Employee dies, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine months, subject to the "When Continuation Ends" paragraph of this subsection.

- If an Employee's Marriage Ends: If the Employee's marriage ends due to legal divorce or legal separation, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to nine months, subject to the "When Continuation Ends" paragraph of this subsection.

- If a Dependent Loses Eligibility: If the Employee's Dependent child's group health benefits end due to the Dependent's loss of dependent eligibility as defined in this Benefit Booklet, other than the Employee's coverage ending, the Dependent may elect to continue such benefits. However, such Dependent child must be a qualified beneficiary. The continuation can last for up to nine months, subject to the "When Continuation Ends" paragraph of this subsection.

- Election of Continuation: To continue the qualified beneficiary's group health benefits, the qualified beneficiary must give the plan administrator written notice that the qualified beneficiary elects to continue benefits under the coverage. This must be done within 30 days of the date a qualified beneficiary receives notice of the qualified beneficiary's continuation rights from the plan administrator as described above or 30 days of the date the qualified beneficiary's group health benefits end, if later. The Employer must notify the Health Benefit Plan of the qualified beneficiary's election of continuation within 14 days of the election of continuation. Furthermore, the qualified beneficiary must pay the first month's premium in a timely manner.

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

  The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified beneficiary stayed insured under this benefit plan on a regular basis. It includes any amount that would have been paid by the employer. An additional administrative charge of up to 5% of the total premium charge may also be required by the Health Benefit Plan.

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

- When Continuation Ends: A qualified beneficiary's continued group health benefits under this Program ends on the first to occur of the following:
  - With respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the nine month period which starts on the date the group health benefits would otherwise end;
  - With respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of the Employee's covered Dependent's eligibility, the end of the nine month period which starts on the date the group health benefits would otherwise end;
  - With respect to the Employee's Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the nine month period which starts on the date the group health benefits would otherwise end;
  - The date coverage under this Program ends;
  - The end of the period for which the last premium payment is made;
  - The date the qualified beneficiary becomes covered under any other group health plan (as an employee or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which the qualified beneficiary satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
  - The date the Employee and/or eligible dependent become eligible for Medicare.

THE HEALTH BENEFIT PLAN'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER THIS PROGRAM ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION OF THIS BENEFIT BOOKLET.

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

Continuation Of Incapacitated Child

If the Member’s unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on the Member for over half of their support, the Member may apply to the Health Benefit Plan to continue coverage of such child under this Program upon such terms and conditions as the Health Benefit Plan may determine. Coverage of such Dependent child shall terminate upon the child’s marriage. Continuation of benefits under this provision will only apply if the child was eligible as a Dependent and mental or physical incapacity commenced prior to age 19.

The disability must be certified by the attending physician; furthermore, the disability is subject to annual medical review. In a case where a handicapped child is over the limiting age and joining the Health Benefit Plan for the first time, the handicapped child must have been covered under the prior Health Benefit Plan and submit proof from the prior Health Benefit Plan that the child was covered as a handicapped person.

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

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

Release Of Information
Each Member agrees that any person or entity having information relating to any Services or Supplies for which benefits are claimed under this Program may furnish to the Health Benefit Plan, upon its request, any information (including copies of records) relating to the illness or injury. In addition, the Health Benefit Plan may furnish similar information to other entities providing similar benefits at their request. The Health Benefit Plan shall provide to the Contractholder, at the Contractholder's request, any and all information regarding claims and charges submitted to the Health Benefit Plan by Professional Providers. The Parties understand that any information provided to the Contractholder will be adjusted by the Health Benefit Plan to prevent the disclosure of the identity of any Member or other patient treated by said Professional Providers. The Contractholder shall reimburse the Health Benefit Plan for the actual costs of preparing and providing said information. The Health Benefit Plan shall provide the Contractholder with such cost figure and obtain the Contractholder's approval of such expense prior to incurring such costs.

The Health Benefit Plan may also furnish membership and/or coverage information for the purpose of claims processing or facilitating patient care.

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

Claim Forms
The Health Benefit Plan will furnish to the Member making the claim, or to the Contractholder, for delivery to such Member, such forms as are required for filing proof of loss.

Time Of Payment Of Claims
All benefits payable under this Program will be payable not more than 60 days after receipt of proof.

Right To Recover Payments In Error
If the Health Benefit Plan should pay for any contractually excluded services through inadvertence or error, the Health Benefit Plan maintains the right to seek recovery of such payment from the Professional Provider, Supplier or Member to whom such payment was made.

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

Member/Provider Relationship
- The choice of a provider is solely the Member's.
- The Health Benefit Plan does not furnish Covered Services but only makes payment for Covered Services received by Members. The Health Benefit Plan is not liable for any act or omission of any Professional Provider or Supplier. The Health Benefit Plan has no responsibility for a Professional Provider's or Supplier's failure or refusal to render Covered Services to a Member.

Agency Relationships
The Contractholder is the agent of the Member, not the Health Benefit Plan.

Identification Cards And Benefit Booklets
The Health Benefit Plan will provide the Identification Cards to Members or to the Contractholder, depending on the direction of the Contractholder. The Health Benefit Plan will also provide to each Member of an Enrolled Group a Benefit Booklet describing the benefits provided under the Group Contract.

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

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

Subrogation and Reimbursement Rights
By accepting benefits for Allowable Charges, the Member agrees that the Health Benefit Plan has the right to enforce subrogation and reimbursement rights. This section explains these rights and the responsibilities of each Member pertaining to subrogation and reimbursement. The term Member includes Eligible Dependents. The term Responsible Third Party refers to any person or entity, including any insurance company, health benefits plan or other third party, that has an obligation (whether by contract, common law or otherwise) to pay damages, pay compensation, provide benefits or make any type of payment to the Member for an injury or illness.

The Health Benefit Plan or the Plan Administrator, as applicable, retains full discretionary authority to interpret and apply these subrogation and reimbursement rights based on the facts presented.

- Subrogation Rights
  Subrogation rights arise when the Health Benefit Plan pays benefits on behalf of a Member and the Member has a right to receive damages, compensation, benefits or payments of any kind (whether by a court judgment, settlement or otherwise) from a Responsible Third Party. The Health Benefit Plan is subrogated to the Member's right to recover from the Responsible Third Party. This means that the Health Benefit Plan "stands in your shoes" - and assumes the Member's right to pursue and receive the damages, compensation, benefits or payments from the Responsible Third Party to the full extent that the Health Benefit Plan has reimbursed the Member for medical expenses or paid medical expenses on the Member's behalf, plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights. The right to pursue a subrogation claim is not contingent upon whether or not the Member pursues the Responsible Third Party for any recovery.

- Reimbursement Rights
  If a Member obtains any recovery - regardless of how it's described or structured - from a Responsible Third Party, the Member must fully reimburse the Health Benefit Plan for all medical expenses that were paid to the Member or on the Member's behalf, plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights. The Health Benefit Plan has a right to full reimbursement.

- Lien
  By accepting benefits for Allowable Charges from the Health Benefit Plan, the Member agrees to a first priority equitable lien by agreement on any payment, reimbursement, settlement or judgment received by the Member, or anyone acting on the Member's behalf, from any Responsible Third Party. As a result, the Member must repay to the Health Benefit Plan the full amount of the medical expenses that were paid to the Member or on the Member's behalf out of the amounts recovered from the Responsible Third Party (plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights) first, before funds are allotted toward any other form of damages, whether or not there is an admission of fault or liability by the Responsible Third Party. The Health Benefit Plan has a lien on any amounts recovered by the Member from a Responsible Third Party, regardless of whether or not the amount is designated as payment for medical expenses. This lien will remain in effect until the Health Benefit Plan is reimbursed in full.

- Constructive Trust
  If the Member (or anyone acting on the Member's behalf) receive damages, compensation, benefits or payments of any type from a Responsible Third Party (whether by a court judgment, settlement or otherwise), the Member agrees to maintain the funds in a separate, identifiable account and that the Health Benefit Plan has a lien on the monies. In addition the Member agrees to serve as the trustee over the monies for the benefit of the Health Benefit Plan to the full extent that the Health Benefit Plan has reimbursed the Member for medical expenses or paid medical expenses on the member's behalf, plus the attorney's fees and the costs of collection incurred by the Health Benefit Plan.
  – These subrogation and reimbursement rights apply regardless of whether money is received through a court decision, settlement, or any other type of resolution.
  – These subrogation and reimbursement rights apply even if the recovery is designated or described as covering damages other than medical expenses (such as property damage or pain and suffering).
  – These subrogation and reimbursement rights apply with respect to any recoveries made by the Member, including amounts recovered under an uninsured or underinsured motorist policy.

- The Health Benefit Plan is entitled to recover the full amount of the benefits paid to the Member or on the Member's behalf plus the costs and fees that are incurred by the Health Benefit Plan to enforce these rights without regard to whether the Member has been made whole or received full compensation for other damages (including property damage or pain and suffering). The recovery rights of the Health Benefit Plan will not be reduced by the "made whole" doctrine or "double recovery" doctrine.
- The Health Benefit Plan will not pay, offset any recovery, or in any way be responsible for attorneys' fees or costs associated with pursuing a claim against a Responsible Third Party unless the Health Benefit Plan agrees to do so in writing. The recovery rights of the Health Benefit Plan will not be reduced by the "common fund" doctrine.
- In addition to any Coordination of Benefits rules described in this Benefit Booklet, the benefits paid by the Health Benefit Plan will be secondary to any no-fault auto insurance benefits and to any worker's compensation benefits (no matter how any settlement or award is characterized) to the fullest extent permitted by law.
- These subrogation and reimbursement rights apply and will not be decreased, restricted, or eliminated in any way if the Member receives or has the right to recover no-fault insurance benefits. All rights under this section are enforceable against the heirs, estate, legal guardians or legal representatives of the Member.
- The Health Benefit Plan is entitled to recover the full amount of the medical benefits paid without regard to any claim of fault on the Member's part.

- Obligations of Member
  - Immediately notify the Health Benefit Plan or its designee in writing if the Member asserts a claim against a Responsible Third Party, whether informally or through judicial or administrative proceedings.
  - Immediately notify the Health Benefit Plan or its designee in writing whenever a Responsible Third Party contacts the Member or the Member's representative - or the Member or the Member's representative contact a Responsible Third Party - to discuss a potential settlement or resolution.
  - Refuse any offer to settle, adjust or resolve a claim for damages, benefits or compensation that involves an injury, illness or medical expenses in any way, unless and until the Member receives written authorization from the Health Benefit Plan or its delegated representative.
  - Fully cooperate with the Health Benefit Plan and its designated representative, as needed, to allow for the enforcement of these subrogation and reimbursement rights and promptly supply information/documentation when requested and promptly execute any and all forms/documents that may be needed.
  - Avoid taking any action that may prejudice or harm the Health Benefit Plan ability to enforce these subrogation and reimbursement rights to the fullest extent possible.
  - Fully reimburse the Health Benefit Plan or its designated representative immediately upon receiving compensation of any kind (whether by court judgment, settlement or otherwise) from a Responsible Third Party.
  - Serve as trustee for any and all monies paid to (or payable to) the Member or for the Member's benefit by any Responsible Third Party to the full extent the Health Benefit Plan paid benefits for an injury or illness.
  - All of these Obligations apply to the heirs, estate, legal guardians or legal representatives of the Member.

Special Circumstances
In the event that Special Circumstances result in a severe impact to the availability of providers and services, to the procedures required for obtaining benefits for Covered Services under this Program (For Example, use of Participating Providers), or to the administration of this Program by the Health Benefit Plan, the Health Benefit Plan may on a selective basis, waive certain procedural requirements of this Program. Such waiver shall be specific as to the requirements that are waived and shall last for such period as required by the Special Circumstances as defined below.

The Health Benefit Plan shall make a good faith effort to provide access to Covered Services in so far as practical and according to its best judgment. Neither the Health Benefit Plan nor the Participating Providers shall incur liability or obligation for delay or failure to provide or arrange for Covered Services if such failure or delay is caused by Special Circumstances.

Special Circumstances, as recognized in the community, and by the Health Benefit Plan and appropriate regulatory authority, are extraordinary circumstances not within the control of the Health Benefit Plan, including but not limited to:
- Major disaster;
- Epidemic;
- Pandemic;
- The complete or partial destruction of facilities;
- Riot; or
- Civil insurrection.

Regarding Non-Discrimination Rights
The Member has the right to receive health care services without discrimination;
- Based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, national origin, source of payment, sexual orientation, or sex, including stereotypes and gender identity;
- For Medically Necessary health services made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender;
- Based on an individual's sex assigned at birth, gender identity, or recorded gender, if it is different from the one to which such health service is ordinarily available;
- Related to gender transition if such denial or limitation results in discriminating against a transgender individual.

SECTION 6 - RESOLVING PROBLEMS (COMPLAINTS/APPEALS)

Member Complaint Process

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

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

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

Member Appeal Process

- Filing an Appeal

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

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

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

- Types of Member Appeals and Timeframe Classifications

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

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

- Standard Pre-service appeal - An appeal for benefits that, under the terms of the Program, must be precertified or pre-approved (either in whole or in part) before medical care is obtained in order for coverage to be available.
- Standard Post-service appeal - An appeal for benefits that is not a Pre-service appeal. (Post-service appeals concerning claims for services that the Member has already obtained do not qualify for review as expedited/urgent appeals.)
- Expedited/Urgent appeal – An appeal that provides faster review, according to the procedures described below, on a pre-service issue. The Health Benefit Plan will conduct an expedited appeal on a pre-service issue when it determines, based on applicable guidelines, that delay in decision-making would seriously jeopardize the Member's life, health or ability to regain maximum function or would subject the Member to severe pain that cannot be adequately managed while awaiting a standard appeal decision.

- Information for the Appeal Review including Matched Specialist's Report
  The Member may submit to the Health Benefit Plan additional information pertaining to the Member's case. The Member may specify the remedy or corrective action being sought. Upon request at any time during the appeal process, the Health Benefit Plan will provide the Member or the Member's authorized representative access to, and copies of, documents, records, and other information relevant to the appeal that is provided for the appeal decision maker(s) to review.
  Input from a matched specialist is obtained for all Medical Necessity Appeals. A matched specialist is a licensed Physician or psychologist in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the adverse benefit determination at issue in the appeal and cannot be a subordinate of the person who made that determination.

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

STANDARD APPEALS: Process and timeframes

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

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

The appeal review will occur based on the information available for the Appeal Committee's review. The Member is encouraged to supply additional relevant information to the appeals specialist preparing the appeal.

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

The standard appeal decision is final with respect to the Member's right to appeal through the Health Benefit Plan's internal member appeal process.

EXPEDITED APPEALS: Process and timeframes

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

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

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

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

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

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

SECTION 7 – IMPORTANT DEFINITIONS

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

Accredited Educational Institution
A publicly or privately operated academic institution of higher learning which:
- Provides recognized course or courses of instruction and leads to the conference of a diploma, degree, or other recognized certification of completion at the conclusion of the course of study; and
- Is duly recognized and declared as such by the appropriate authority of the state in which such institution is located; provided, however, that in addition to any state recognition, the institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education.

The definition may include, but is not limited to, colleges and universities, and technical or specialized schools.

Benefit Period
The specified period of time during which charges for Covered Services must be Incurred in order to be eligible for payment by the Health Benefit Plan. A charge shall be considered Incurred on the date the service or supply was provided to a Member.

Billed Charge
An amount billed by a Supplier or Professional Provider for treatment, services or supplies rendered to a Member.

Coinsurance
A specific percentage of the Provider's Reasonable Charge for Covered Services set forth in the section entitled *Schedule of Benefits* of this Benefit Booklet, for which the Member is responsible.
- Program Coinsurance - a specified percentage of the Provider's Reasonable Charge applied to all Covered Services for which the Member is responsible.
- Benefit Coinsurance - a specified percentage of the Provider's Reasonable Charge applied to a specific Covered Service for which the Member is responsible.

Contract
The Group Policy of Vision Care Benefits, including the Group Application, riders and/or endorsements, if any, between the Health Benefit Plan and the Contractholder, also referred to as the Group Contract.

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

Copayment
A specified amount of expenses applied to a specific Covered Service for which the Member is responsible per Covered Service.

Covered Service
A service or supply specified in this Benefit Booklet for which benefits will be provided when rendered by a Professional Provider or Supplier. For purposes of this Program, the term "Covered Services and Supplies" means Covered Services, with the exception of Eye Examination Services.

Dependent
A Member other than the Employee as specified in the section entitled *Who Is Covered.*

Effective Date
A date on which coverage for a Member begins under the Group Contract.

Employee
An individual in the Contractholder who meets the eligibility requirements for enrollment and who is so specified for enrollment.

Eye Examination Services
A comprehensive examination and evaluation of the eyes performed by a physician, Ophthalmologist or Optometrist, which shall include, but not be limited to, the services listed in the "Eye Examination Services" subsection of the section entitled *Vision Care Benefits*.

Family Coverage
Coverage for the Employee and one or more of the Employee's Dependents.

Incurred
A charge shall be considered Incurred on the date a Member receives the service or supply for which the charge is made.

Lens
A transparent refracting medium, usually made of plastic.
- Aphakic - a lens prescribed for those who have had the crystalline lens of the eye removed during cataract surgery or who were born without a crystalline lens.
- Bifocal - a lens containing two different powers, one for distance vision, and one for near vision.
- Disposable Contact - a soft plastic contact lens that is applied to the eye for correcting refractive errors for a period of approximately one to two weeks and is then discarded.
- Hard Contact - a curved glass or plastic lens that is applied to the eye for correction of refractive errors.
- Lenticular - a type of aphakic lens prescribed to replicate the crystalline lens of the eye.
- Single Vision - a lens with one correction, for either distance or near vision.
- Soft Contact - a lens for correcting refractive errors. They are of soft plastic material.
- Trifocal - a lens that has three distinct areas for visual focus.

Limitations
The Maximum frequency as set forth in the section entitled *Schedule of Benefits*, for which a Covered Service is allowed.

Maximum
The greatest amount payable by the Health Benefit Plan set forth in the *Schedule of Benefits*, for Covered Services. This could be expressed in dollars or a specified number of services for a specified period of time.

- Program Maximum - the greatest amount payable by the Health Benefit Plan for Covered Services.
- Benefit Maximum - the greatest amount payable by the Health Benefit Plan for a specific Covered Service.

Member
An enrolled Employee and their Eligible Dependents who have satisfied the specifications under the section entitled ***Who Is Covered*** of this Benefit Booklet.

Non-Participating Provider
A Professional Provider that does not participate in the Health Benefit Plan's programs and is not required to accept the Health Benefit Plan's payment as payment-in-full.

Ophthalmologist
Is a Physician who specializes in the diagnosis, treatment and prescription of medications and lenses related to conditions of the eye, and who may perform Eye Examination and Refractive Services.

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

Optometrist
Is a person licensed to practice optometry in accordance with the provisions of the Optometric Practice and Licensure Act, and whom may perform Eye Examination and Refractive Services.

Participating Provider
A Provider that has an agreement with the Health Benefit Plan pertaining to payment for Covered Services rendered to a Covered Person.

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

Professional Provider
A person or practitioner licensed where required and performing within the scope of such licensure. The Professional Providers include:

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

Provider's Reasonable Charge
The dollar amount on which a Member's Coinsurance, Benefit Maximums and benefits will be calculated. "Provider's Reasonable Charge" shall mean the following:

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

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

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

Total Disability
Except as otherwise specified in this Benefit Booklet, a Member who, due to illness or injury, cannot perform any duty of their occupation or any occupation for which they are, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if they cannot engage in the normal activities of a person in good health and of like age and sex. The Member or Dependent person must be under the regular care of a Physician.

INDEPENDENCE BLUE CROSS
NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

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

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

We protect your privacy by:

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

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

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

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

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

Copies of this Notice

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

Changes to this Notice

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

Potential Impact of State Law

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Health Information Exchanges

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

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

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

Right to Provide an Authorization for Other Uses and Disclosures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You will not be penalized for filing a complaint.

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

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

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