MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Vision Care Policy

This Vision Care Policy is part of the agreement between the *subscriber's group* and Blue Cross and Blue Shield of Massachusetts, Inc., located at Landmark Center, 401 Park Drive, Boston, Massachusetts 02215-3326, to provide vision care benefits to participants of the group vision care plan sponsored by the *subscriber's group*. *Blue Cross and Blue Shield* will provide the vision care benefits described in this Vision Care Policy as long as you are enrolled in this vision care plan when you receive *covered services* and the *premium* that your *group* owes for these vision care benefits has been paid to *Blue Cross and Blue Shield*. You should read all parts of this Vision Care Policy, including your *Schedule of Vision Care Benefits* to become familiar with the key points. You should keep them handy so that you can refer to them. The words that are shown in italics have special meanings. These words are explained in Part 9 of this Vision Care Policy.

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Blue Cross and Blue Shield of Massachusetts, Inc.

Andrew Dreyfus
President

BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS, INC. 1937

Stephanie Lovell
Clerk/Secretary

Incorporated under the laws of the
Commonwealth of Massachusetts as a Non-Profit Organization

Translation and Interpretation Services

A language translator service is available when you call the *Blue Cross and Blue Shield* customer service office at the toll-free telephone number shown on your health plan identification card. This service provides you with access to interpreters who are able to translate over 140 different languages. If you need these translation services, just tell the customer service representative when you call. Then during your call, *Blue Cross and Blue Shield* will use a language line service to access an interpreter who will assist in answering your questions or helping you to understand *Blue Cross and Blue Shield* procedures. (This interpreter is not an employee or designee of *Blue Cross and Blue Shield.*)

Traduction et interprétation en ligne

Un service de traduction et d'interprétation est disponible lorsque vous appelez le service clientèle de Blue Cross and Blue Shield au numéro gratuit figurant sur la carte d'identification de votre plan de santé. Ce service vous donne accès à des interprètes qui peuvent traduire dans plus de 140 langues. Si vous avez besoin de ces services, mentionnez-le à l'agent du service clientèle lorsque vous nous appelez. Ensuite, au cours de votre appel, Blue Cross and Blue Shield utilisera un service de traduction et d'interprétation en ligne pour joindre un interprète qui assurera la traduction des questions que vous poserez ou qui vous aidera à comprendre les procédures de Blue Cross and Blue Shield. (Cet interprète n'est pas un employé de Blue Cross and Blue Shield ni une personne mandatée par Blue Cross and Blue Shield.)

Sèvis Tradiksyon ak Entèpretasyon

Genyen yon sèvis tradiksyon ki disponib lè w rele biwo sèvis kliyan Blue Cross and Blue Shield nan nimewo telefòn gratis ki sou kat didantifikasyon plan asirans ou an Sèvis sa a ba w aksè a entèprèt ki ka tradwi plis ke 140 lang diferan. Si w ta bezwen itilize sèvis tradiksyon sa yo, senpleman di reprezantan sèvis kliyan an sa lè w rele. Epi lè w rele a, Blue Cross and Blue Shield pral itilize yon liy sèvis pou lang pou gen aksè a yon entèprèt ki pral ede w jwenn repons a keksyon ou genyen oswa ede w konprann pwosedi Blue Cross and Blue Shield yo. (Entèprèt sa a pa yon anplwaye Blue Cross and Blue Shield ni tou li pa mandate pa Blue Cross and Blue Shield.)

Servizio di traduzione e di interpretariato

Quando chiamate l'ufficio di assistenza clienti Blue Cross and Blue Shield al numero verde indicato sulla vostra tessera sanitaria avrete a disposizione un servizio di traduzione nella vostra lingua. Tramite tale servizio potrete accedere ad interpreti in grado di tradurre in oltre 140 lingue diverse. Qualora aveste bisogno di un servizio di traduzione, fatelo presente al rappresentante del servizio clienti durante la vostra chiamata; in questo caso Blue Cross and Blue Shield utilizzerà un servizio in linea di lingue straniere per chiamare un interprete che vi aiuterà a rispondere alle domande ed a comprendere le procedure Blue Cross and Blue Shield. (L'interprete non è un dipendente e non è selezionato da Blue Cross and Blue Shield.)

សេវាផ្នែកបកប្រែភាសាសរសេរ និងបកប្រែផ្ទាល់មាត់

សេវាផ្នែកបកប្រែភាសាអាចមានផ្តល់ជូនកាលណាអ្នកទូរស័ព្ទមកកាន់ការិយាល័យផ្នែកសេវាបំរើអតិថិជនរបស់ Blue Cross and Blue Shield តាមលេខទូរស័ព្ទឥតបង់ថ្លៃដែលមានទៅក្នុងអត្តសញ្ញាណប័ណ្ណផែនការសុខភាពរបស់អ្នក ។ សេវានេះផ្តល់ឲ្យអ្នកនូវលទ្ធភាពទាក់ទងជាមួយក្រុមអ្នកបកប្រែភាសាជាច្រើនដែលមានលទ្ធភាពបកប្រែភាសាលើសពី ១៤០ ភាសាទៅទៀត ។ បើអ្នកត្រូវការសេវាផ្នែកបកប្រែភាសាទាំងនេះគ្រាន់តែប្រាប់អ្នកតំណាងផ្នែកសេវាអតិថិជនកាលណាអ្នកទូរស័ព្ទមក ។ នៅពេលដែល អ្នកទូរស័ព្ទមក Blue Cross and Blue Shield នឹងប្រើបណ្តាញសេវាភាសា ដើម្បីរកអ្នកបកប្រែណា ម្នាក់ដែលគេនឹងជួយឆ្លើយសំនួររបស់អ្នកឬជួយអ្នកឲ្យយល់អំពីទម្រង់ការរបស់ក្រុមហ៊ុន Blue Cross and Blue Shield ។ (អ្នកបកប្រែនេះមនមែនជានិយោជក ឬអ្នកចាត់តាំងរបស់ Blue Cross and Blue Shield ទេ ។)

翻譯服務

當您以健康計劃識別卡上的免付費電話號碼致電 Blue Cross and Blue Shield 客戶服務辦公室之時，您就能獲得語言翻譯服務。這項服務能提供您 140 多種不同語言的翻譯服務。若您需要翻譯服務，在致電時告訴客戶服務代表即可。隨後 Blue Cross and Blue Shield 會利用一電話公司的語言服務專線找一個翻譯，為您釋疑或幫助您了解 Blue Cross and Blue Shield 程序。（此翻譯並非Blue Cross and Blue Shield 的雇員或所指派的人。）

Υπηρεσίες Μετάφρασης και Διερμηνείας

Υπάρχει ξενόγλωσση υπηρεσία όταν τηλεφωνείτε στην εξυπηρέτηση πελατών της Blue Cross and Blue Shield στον ατελή αριθμό που αναγράφεται στην κάρτα του ασφαλιστικού σας προγράμματος. Η υπηρεσία αυτή σάς παρέχει πρόσβαση σε διερμηνείς που μπορούν να μεταφράσουν 140 διαφορετικές γλώσσες. Αν χρειάζεστε μεταφραστικές υπηρεσίες, να το λέτε στον αντιπρόσωπο εξυπηρέτησης πελατών όταν τηλεφωνείτε. Στη συνέχεια, η Blue Cross and Blue Shield θα επικοινωνήσει με μια ξενόγλωσση τηλεφωνική υπηρεσία για να φέρει στο τηλέφωνο διερμηνέα που θα σας βοηθήσει για να πάρετε απάντηση στις ερωτήσεις σας ή για να καταλάβετε τις διαδικασίες του Blue Cross and Blue Shield. (Ο διερμηνέας δεν είναι υπάλληλος ούτε αντιπρόσωπος της Blue Cross and Blue Shield.)

Услуги по письменным и устным переводам

Позвонив в отдел обслуживания клиентов медицинского плана Blue Cross and Blue Shield по бесплатному телефону, указанному в вашем удостоверении клиента плана, вы можете воспользоваться услугами переводчика. В распоряжении наших клиентов имеются переводчики, работающие с более чем 140 языками. Если вы нуждаетесь в переводе, сообщите об этом ответившему на ваш звонок сотруднику отдела обслуживания клиентов плана. В этом случае план Blue Cross and Blue Shield свяжется с переводчиком службы переводов, который переведет для вас ответы на ваши вопросы и поможет вам понять правила, действующие в плане Blue Cross and Blue Shield. (Такой переводчик не является сотрудником или назначенным лицом плана Blue Cross and Blue Shield.)

خدمات الترجمة التحريرية و الشفوية

عندما تتصل بقسم خدمة العميل لدى Blue Cross and Blue Shield على الرقم المجاني الذي تجده مطبوعاً على بطاقة تأمينك الصحي، تستطيع الاستفادة من خدمة الترجمة. توفر لك هذه الخدمة إمكانية الاتصال بمترجمين لأكثر من 140 لغة. إذا كنت في حاجة إلى الترجمة، عليك فقط بإخبار موظف خدمة العميل عندما تتصل. و أثناء اتصالك، ستستخدم Blue Cross and Blue Shield خدمات ترجمة على الهاتف للاتصال بالمترجم الذي سيساعد في الإجابة على أسئلتك أو يساعدك على فهم إجراءات Blue Cross and Blue Shield. (هذا المترجم ليس موظفاً أو معيناً من قبل Blue Cross and Blue Shield).

ຫ້ອງການຊ່ວຍ ບໍຣິການດ້ານແປພາສາ

ນີ້ມາຍພາສາຈະຊ່ວຍທ່ານໄດ້ ເມື່ອໂທລະສັບໄປຫາ ຫ້ອງການຊ່ວຍລູກຄ້າ ຂອງ Blue Cross and Blue Shield ທີ່ມີໂທລະສັບໂທຟີ ຢູ່ໃນບັດສຸກຂະພາບຂອງທ່ານ. ໃນ ຫ້ອງການບໍຣິການນີ້ມີນາຍພາສາ ທີ່ສາມາດແປຫລາຍກວ່າ 140 ພາສາໃຫ້ທ່ານ. ຫາກທ່ານຕ້ອງການ ບໍຣິການນີ້, ບອກໃຫ້ຜູ້ຕາງໜ້າຊ່ວຍລູກຄ້າ ເມື່ອທ່ານໂທໄປ. ໃນຍາມທ່ານໂທໄປຫາ , Blue Cross and Blue Shield ຈະໃຊ້ ສາຍໂທລະສັບສາຍນຶ່ງ ຫານາຍພາສາ ທີ່ຈະຊ່ວຍທ່ານຕອບຄຳຖາມຫລື ຊ່ວຍ ທ່ານໃຫ້ເຂົ້າໃຈການແນ່ນຳຂອງ Blue Cross and Blue Shield. (ນາຍພາສາ ຜູ້ນີ້ບໍ່ແມ່ນ ພະນັກງານ ຫລືຜູ້ແນ່ນຳຂອງ Blue Cross and Blue Shield.)

Servicio de Traducción e Interpretatión

Disponemos de un servicio de traductores para cuando usted llame a la oficina de atención al cliente de Blue Cross and Blue Shield al número de teléfono de la línea gratuita que figura en su tarjeta de identificación del plan de salud. A través de este servicio, usted tiene acceso a intérpretes que pueden traducir a más de 140 idiomas diferentes. Si usted necesita este servicio de traducción, simplemente solicítelo al representante de atención al cliente al hacer su llamada. Durante su llamada telefónica, Blue Cross and Blue Shield utilizará un servicio de línea de idiomas para ponerlo en contacto con un intérprete que lo ayudará a responder sus preguntas o a entender los procedimientos de Blue Cross and Blue Shield. (Este intérprete no es un empleado de Blue Cross and Blue Shield, ni ha sido designado por Blue Cross and Blue Shield.)

Serviço de Tradução e Interpretação

O serviço de apoio aos clientes da Blue Cross and Blue Shield tem disponível um serviço de tradução, quando telefona para o número grátis indicado no seu cartão de identificação do plano de saúde. Este serviço dá acesso a intérpretes em mais de 140 idiomas diferentes. Se necessitar destes serviços de tradução, comunique-o ao representante do serviço de clientes que o atender via telefone. Então, durante a sua chamada, a Blue Cross and Blue Shield utilizará um intérprete de um serviço de interpretação por telefone, que o ajudará a obter respostas às suas questões ou a entender os procedimentos da Blue Cross and Blue Shield. (Este intérprete não é um funcionário da Blue Cross and Blue Shield.)

Part 1

Vision Care Benefits

This vision care plan is a preferred provider plan (also referred to as a PPO plan). This means that the costs that you will pay for *covered services* will differ based on the vision care provider you choose. You will receive the highest level of benefits when you use vision care providers who participate in your designated vision care network. These are called your "in-network benefits." If you choose to use covered vision care providers who do not participate in your designated vision care network, you will usually receive a lower level of benefits. In this case, your out-of-pocket costs will be more. These are called your "out-of-network benefits."

This vision care plan is not a part of any health plan that you may have with *Blue Cross and Blue Shield* or with Blue Cross and Blue Shield of Massachusetts, HMO Blue, Inc. If you have health coverage, you may wish to verify your vision care coverage in your health plan in addition to your coverage in this vision care plan. This will help you determine how to maximize your vision care benefits.

Covered Services and What You Pay for Covered Services

This Vision Care Policy and your *Schedule of Vision Care Benefits* describes the vision care services that are covered by your vision care plan. Your *Schedule of Vision Care Benefits* also shows the cost share amounts you will pay for each *covered service* and how your cost will vary when you get *covered services* from a *preferred vision care provider* ("in network" provider) and from a non-*preferred vision care provider* ("out-of-network" provider). Do not rely on this schedule alone. Be sure to read all parts of your Vision Care Policy to understand the requirements that you must follow to receive all of your vision care benefits. You should also read the descriptions of *covered services* and the limitations and exclusions that apply for vision care benefits. These provisions are fully described in this Vision Care Policy and your *Schedule of Vision Care Benefits*.

How Your Vision Care Benefits Are Calculated

Blue Cross and Blue Shield calculates payment of your vision care benefits based on the *allowed charge* (sometimes referred to as the *allowed amount*). This is the maximum amount on which payment is based for *covered services*. This may be called "eligible expense," "payment allowance," or "negotiated rate." The *allowed charge* that *Blue Cross and Blue Shield* uses depends on the type of vision care provider you use and the type of *covered service*.

- **Preferred Vision Care Provider (In-Network Provider).** For vision care providers who have a preferred provider arrangement (a "PPO payment agreement") to provide vision care services for *members* enrolled in this vision care plan, the *allowed charge* is based on the provisions of that vision care provider's payment agreement. **For most *covered services* you get from a *preferred vision care provider*, you will not have to pay any amount of the provider's charge that is in excess of the *allowed charge*. However, for certain *covered services*, you will be responsible for the amount of the provider's actual charge that is in excess of the *allowed charge* (known as "*balance billing*")** Refer to your *Schedule of Vision Care Benefits* for the amount you will pay when you get your *covered services* from a *preferred vision care provider*.

- **Non-Preferred Vision Care Provider (Out-of-Network Provider).** For vision care providers who do not have a preferred provider arrangement (a "PPO payment agreement") to provide vision care services for *members* enrolled in this vision care plan, the *allowed charge* is based on the Maximum

Allowable Charge for each specific *covered service*, but not more than the provider's actual charge. The *allowed charge* is generally less than the vision care provider's actual charge. **If you use a non-*preferred vision care provider* to get your *covered services*, you will be responsible for the amount of the provider's actual charge that is in excess of the *allowed charge* (known as "*balance billing*").** You must pay this *balance bill*. Refer to your *Schedule of Vision Care Benefits* for the amounts you will pay when you get a *covered service* from a non-*preferred vision care provider*.

Excluded Services and Charges

No benefits are provided under this vision care plan for:

- A service, supply, procedure, or appliance that is not described as a *covered service* in this Vision Care Policy, including your *Schedule of Vision Care Benefits*. This includes, but is not limited to: orthoptics, vision training, subnormal vision aids, and similar procedures and devices; sunglasses not requiring a prescription; lenses or contact lenses not requiring a prescription; safety glasses; aniseikonic lenses; two pairs of glasses instead of bifocals; replacement of lost or broken lenses, frames, glasses, or contact lenses except in the next eligible time period when vision materials would become available; prescription or non-prescription drugs; and any associated supplemental testing.
- A medical or surgical service to treat disease or injury of the eye, eyes, or supporting structures. This also excludes surgeries to detect or correct refractive errors of the eye.
- A charge for a condition, disease, ailment, injury, or service, supply, procedure, or appliance for which you have the right to benefits under government programs. These programs include: the Veterans Administration for an illness or injury connected to military service; and programs set up by other local, state, federal, or foreign laws or regulations that provide or pay for health care services and supplies (such as Medicaid and Medicare) or that require care to be furnished in a public facility.
- A court-ordered service, supply, or procedure that is otherwise excluded for coverage under this vision care plan.
- A service, supply, procedure, or appliance that is free, or would be free if you were not covered under this vision care plan.
- A service, supply, procedure, or appliance that is furnished by a provider to himself or herself or to a member of his or her immediate family. "Immediate family" means any of the following members of a vision care provider's family: spouse or spousal equivalent; parent, child, brother or sister (by birth or adoption); stepparent, stepchild, stepbrother or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law (for purposes of this exclusion, an in-law relationship does not exist between the vision care provider and the spouse of his or her wife's or husband's brother or sister); and grandparent or grandchild. The immediate family members listed above will still be considered immediate family after the marriage which created the relationship is ended by divorce or death.
- A service, supply, procedure, or appliance that is furnished by a provider who is not licensed, accredited, or certified to perform vision care services consistent with the law.
- A service, supply, procedure, or appliance that is furnished by a provider other than an ophthalmologist, optometrist, or optician acting within the scope of his or her license.
- A service, supply, procedure, or appliance that is required as a condition of employment.
- A service, supply, procedure, or appliance that is furnished before your effective date or after your termination date in this vision care plan, unless the vision materials were ordered before your termination date and services are received within 31 days of that order.
- A service, supply, procedure, or appliance for which benefits are provided by other group benefit plans.

- A service, supply, procedure, or appliance that is furnished more than once in an eligible time period as described in your *Schedule of Vision Care Benefits*. This means that if you do not use the entire allowance for a *covered service* in a single visit, you will not be able to use any remaining balance for the rest of the benefit frequency. This is the case whether or not the care is necessary.
- A charge for any additional services that may be required outside basic vision analyses for contact lenses, except for fitting fees.
- A charge for a visit that you do not keep. A provider may charge you if you fail to keep your planned visit if you do not give his or her office reasonable notice.
- A charge by a provider who is not licensed or certified to furnish the service.
- A provider's charge for shipping and handling or taxes, telephone consultations; and other administrative services.
- A provider's charge to file a claim. Also, a provider's charge to transcribe or copy your records.

Part 2

Member Services

How to Get Help for Questions

Member Service can help you to understand the terms of this *group* vision care plan. They can also help you to resolve a problem or concern that you may have about your vision care benefits. A Member Service representative will work with you to resolve your problem or concern as quickly as possible. *Blue Cross and Blue Shield* will keep a record of each inquiry you, or someone on your behalf, makes to Member Service about coverage in this vision care plan. *Blue Cross and Blue Shield* will keep these records, including the answers to each inquiry, for one year. These records may be reviewed by the Commissioner of Insurance and the Massachusetts Department of Public Health.

- **To Call.** The Member Service toll free phone number to call is shown on your vision care plan ID card. You can call Member Service Monday through Saturday from 7:30 a.m. to 11:00 p.m. and Sunday 11:00 a.m. to 8:00 p.m. (Eastern Time). Calls to this number are free. To use the Telecommunications Device for the Deaf, call 1-866-308-5375. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

- **To Write.** You can write to: Blue Cross and Blue Shield of Massachusetts, Inc., Member Service, c/o EyeMed Vision Care, 4000 Luxottica Place, Mason, OH 45040.

When You Need Help to Find a Preferred Vision Care Provider

There are a few ways for you to find a provider who participates in your vision care provider network. You can use the online provider directory by logging onto **www.blue2020ma.com**. The list of *preferred vision care providers* can change from time to time. This online provider directory will provide you with the most current list of *preferred vision care providers*. You can also call Member Service for help to find a *preferred vision care provider* in your area or to request a list of *preferred vision care providers* to be sent to you.

Your Vision Care Plan Identification Card

When you enroll in this vision care plan, you will receive an identification (ID) card. The ID card will identify you as a person who has the right to coverage as described in this Vision Care Policy. The ID card is for identification purposes only. Tell your vision care provider that you are a *member* of this vision care plan before you receive *covered services*.

What to Do in an Emergency

At the onset of an emergency medical condition that in your judgment requires emergency medical care, you should go to the nearest emergency room. If you need assistance, call 911 or your local emergency phone number.

Part 3
Claims Filing Procedures

Filing a Claim

A *preferred vision care provider* (in-network provider) will file a claim for you when you receive a *covered service*. Just tell your *preferred vision care provider* that you are a *member* of this vision care plan at the time you get your *covered service*. *Blue Cross and Blue Shield* will pay the vision care provider directly for *covered services*.

You will have to file your claim when you receive a *covered service* from a non-*preferred vision care provider* (out-of-network provider). The non-*preferred vision care provider* will ask you to pay the entire charge at the time of the visit or at a later time. It is up to you to pay the non-*preferred vision care provider* and to file a vision care claim to receive your benefits for *covered services*. To file a vision care claim, you must:

- fill out a vision care claim form;
- attach your original itemized bills; and
- mail the claim to the address shown on the vision care claim form.

When you have to file a claim, you can get claim forms from Member Service. Member Service will mail to you all applicable forms within 30 days of your request. Or, you can log on to the Web site at **www.blue2020ma.com** to print a claim form. You must file a claim within one year of the date you received the *covered service*. This vision care plan will **not** have to provide benefits for *covered services* for which a claim is submitted after this one-year period. *Blue Cross and Blue Shield* will send repayment to you for the amount of your benefits for *covered services*.

Timeliness of Claim Payments

Within 30 calendar days after *Blue Cross and Blue Shield* receives a completed request for benefits or payment, *Blue Cross and Blue Shield* will make a decision. When appropriate, *Blue Cross and Blue Shield* will make a payment to the *preferred vision care provider* (or to you when *covered services* are furnished by a non-*preferred vision care provider*) for your claim to the extent of your vision care benefits. Or, *Blue Cross and Blue Shield* will send you and/or the vision care provider a notice in writing of why your claim is not being paid in full or in part. If the request for benefits or payment is not complete or, if *Blue Cross and Blue Shield* needs more information to make a final determination for the claim, *Blue Cross and Blue Shield* will ask for the information or records it needs. In this case, *Blue Cross and Blue Shield* will send their request within 30 calendar days of the date that they received the request for benefits or payment. The additional information they need must be provided to *Blue Cross and Blue Shield* within 45 calendar days of the date their request is sent. If the additional information is provided to *Blue Cross and Blue Shield* within 45 calendar days of their request, *Blue Cross and Blue Shield* will make a decision within the time remaining in the original 30-day claim determination period. Or, *Blue Cross and Blue Shield* will make the decision within 15 calendar days of the date they receive the additional information, whichever is later. If the additional information is not provided to *Blue Cross and Blue Shield* within 45 calendar days of their request, the request for benefits or payment will be denied by *Blue Cross and Blue Shield*. If the additional information is submitted to *Blue Cross and Blue Shield* after these 45 days, then it may be viewed by *Blue Cross and Blue Shield* as a new request for benefits or payment. In this case, *Blue Cross and Blue Shield* will make a decision within 30 days as described earlier in this paragraph.

Part 4

Grievance Program

You have the right to a full and fair review when you disagree with a decision that is made by *Blue Cross and Blue Shield* to deny benefits or payment for a vision care service or supply; or you disagree with how your claim was paid; or you have a complaint about the service you received from *Blue Cross and Blue Shield* or a *preferred vision care provider*.

What to Do if You Have a Claim Problem or Complaint

Most problems or concerns can be handled with just one phone call. For help to resolve a problem or concern, you should first call Member Service. The toll free phone number to call is shown on your *Blue Cross and Blue Shield* vision care plan ID card. A Member Service representative will work with you to help you understand your vision care benefits or to resolve your problem or concern as quickly as possible. When resolving a problem or concern, *Blue Cross and Blue Shield* will consider all aspects of the particular case. This includes looking at: all provisions of this Vision Care Policy; the policies and procedures that support this Vision Care Policy; the vision care provider's input; and your understanding and expectation of vision care benefits. *Blue Cross and Blue Shield* will use every opportunity to be reasonable in finding a solution that makes sense for all parties. *Blue Cross and Blue Shield* will follow its standard guidelines when it resolves your problem or concern. If after speaking with a Member Service representative, you still disagree with the decision that is given to you, you may request a review through *Blue Cross and Blue Shield's* formal grievance program. You may also request this type of review if *Blue Cross and Blue Shield* has not responded within three working days of receiving your inquiry. If this happens, *Blue Cross and Blue Shield* will notify you and let you know the steps you may follow to request a formal grievance review.

When and How to Request a Formal Grievance Review

To request a formal grievance review from the *Blue Cross and Blue Shield* Member Grievance Program, you (or your authorized representative) have three options.

- **To write or send a fax:** The preferred option is for you to send your grievance in writing to Blue Cross Blue Shield of Massachusetts Member Grievance Program, c/o EyeMed Vision Care Quality Assurance Department, 4000 Luxottica Place, Mason, OH 45040. Or, you may fax your grievance to 1-513-492-3259. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a written confirmation within 15 business days.

- **To send an e-mail:** You may send your grievance by e-mail to the Blue Cross Blue Shield of Massachusetts Member Grievance Program at eyemedqa@eyemedvisioncare.com. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a confirmation immediately by e-mail.

- **To make a telephone call:** You may call the Blue Cross Blue Shield of Massachusetts Member Grievance Program at 1-877-226-1115. When your request is made by phone, *Blue Cross and Blue Shield* will send you a written account of the grievance within 48 hours of your phone call.

Once your request is received, *Blue Cross and Blue Shield* will research the case in detail. They will ask for more information if it is needed. *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review. If your grievance is about termination of your coverage for

concurrent services that were previously approved by *Blue Cross and Blue Shield*, the disputed coverage will continue until this grievance review process is completed. This continuation of your coverage does not apply to: services that are limited by a dollar or visit maximum and that exceed that benefit limit; non-*covered services*; or services that were received prior to the time that you requested a formal grievance review; or when a grievance is not received on a timely basis, based on the course of treatment.

All grievances must be received by *Blue Cross and Blue Shield* within one year of the date of treatment, event, or circumstance, such as the date you were told of the service denial or claim denial.

What to Include in a Grievance Review Request

Your request for a formal grievance review should include: the *member's* name, vision care plan ID number, and daytime phone number; a description of the problem; all relevant dates; names of providers or administrative staff involved; and details of the attempt that has been made to resolve the problem. If *Blue Cross and Blue Shield* needs to review medical records and treatment information that relate to the grievance, *Blue Cross and Blue Shield* will promptly send you an authorization form to sign if needed. You must return this signed form to *Blue Cross and Blue Shield*. It will allow for the release of your medical records. You also have the right to look at and get copies (free of charge) of records and criteria that *Blue Cross and Blue Shield* has and that are relevant to your grievance, including the identity of any experts who were consulted.

Authorized Representative

You may choose to have another person act on your behalf during the grievance review process. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. Or, he or she may appoint another party to be the authorized representative.

Who Handles the Grievance Review

All grievances are reviewed by professionals who are knowledgeable about *Blue Cross and Blue Shield* and the issues involved in the grievance. The professionals who will review your grievance will not be those who participated in any of *Blue Cross and Blue Shield's* prior decisions regarding the subject of your grievance, nor do they work for anyone who did. When a grievance is related to a medical necessity denial, at least one grievance reviewer is an individual who is an actively practicing health care or vision care professional in the same or similar specialty who usually treats the condition or provides treatment that is the subject of your grievance.

Response Time

The review and response for *Blue Cross and Blue Shield's* formal grievance review will be completed within 30 calendar days. If your grievance review begins after an inquiry, the 30-day response time will begin on the day you tell *Blue Cross and Blue Shield* that you disagree with *Blue Cross and Blue Shield's* answer and would like a formal grievance review. Every reasonable effort will be made to speed up the review of grievances that involve vision care services that are soon to be obtained by the *member*. With your permission, *Blue Cross and Blue Shield* may extend the 30-calendar-day time frame to complete a grievance review. This will happen in those cases when *Blue Cross and Blue Shield* and the *member* agree that additional time is required to fully investigate and respond to the grievance. *Blue Cross and Blue Shield* may also extend the 30-calendar-day time frame when the grievance review requires a review of your medical or vision care records and *Blue Cross and Blue Shield* requires your authorization to get these records. The 30-day response time will not include the days from when *Blue Cross and Blue Shield* sends you the authorization form to sign until it receives your signed authorization form (if needed). If

Blue Cross and Blue Shield does not receive your authorization within 30 working days after your grievance is received, *Blue Cross and Blue Shield* may make a final decision about your grievance without that information. In any case, for a grievance review involving vision care services that have not yet been obtained by you, *Blue Cross and Blue Shield* will ask for your permission to extend the 30-day time frame if it cannot complete the review within 30 calendar days of receipt of your grievance. A grievance that is not acted upon within the time frames specified by applicable federal or state law will be considered resolved in favor of the *member*.

Written Response

Once the grievance review is completed, *Blue Cross and Blue Shield* will let you know in writing of the decision or the outcome of the review. If *Blue Cross and Blue Shield* continues to deny benefits for all or part of a service, *Blue Cross and Blue Shield* will send an explanation to you. This notice will include: information related to the details of your grievance; the reasons that *Blue Cross and Blue Shield* has denied the request and the applicable terms of your Vision Care Policy; the specific medical and scientific reasons for which *Blue Cross and Blue Shield* has denied the request; any alternative treatment or services and supplies that would be covered; and clinical guidelines that apply and were used and any review criteria.

Grievance Records

You have the right to look at and get copies of records and criteria that *Blue Cross and Blue Shield* has and that are relevant to your grievance. These copies will be free of charge. *Blue Cross and Blue Shield* will maintain a record of all formal grievances, including the response for each grievance review, for up to seven years.

Part 5
Other General Provisions

Access to and Confidentiality of Medical Records

Blue Cross and Blue Shield and health care and vision care providers may, in accordance with applicable law, have access to all of your medical records and related information that is needed by *Blue Cross and Blue Shield* or the health care or vision care providers. *Blue Cross and Blue Shield* may collect information from health care and vision care providers, other insurance companies, or from your *plan sponsor*. *Blue Cross and Blue Shield* will use this information to help them administer the benefits described in this Vision Care Policy. They will also use it to get facts on the quality of care that is provided under this and other health care and vision care plans. In accordance with law, *Blue Cross and Blue Shield* and health care and vision care providers may use this information, and may disclose it to necessary persons and entities as follows: (1) for administering benefits (including coordination of benefits with other insurance or health benefit plans), disease management programs, managing care, quality assurance, utilization management, the prescription drug history program, grievance and claims review activities, or other specific business, professional, or insurance functions for *Blue Cross and Blue Shield*; (2) for bona fide medical research according to the regulations of the U.S. Department of Health and Human Services and the U.S. Food and Drug Administration for the protection of human subjects; (3) as required by law or valid court order; (4) as required by government or regulatory agencies; and (5) as required by the *subscriber's group* or by its auditors to make sure that *Blue Cross and Blue Shield* is administering this Vision Care Policy properly.

To get a copy of *Blue Cross and Blue Shield's* Commitment to Confidentiality statement, call *Blue Cross and Blue Shield* Member Service. *Blue Cross and Blue Shield* will not share information about you with the Medical Information Bureau (MIB). *Blue Cross and Blue Shield* respects your right to privacy. *Blue Cross and Blue Shield* will not use or disclose personally identifiable information about you without your permission, unless the use or disclosure is permitted or required by law and is done in accordance with the law. You have the right to get the information *Blue Cross and Blue Shield* collects about you. You may also ask *Blue Cross and Blue Shield* to correct any of this information that you believe is not correct. *Blue Cross and Blue Shield* may charge you a reasonable fee for copying your records, unless your request is because *Blue Cross and Blue Shield* is declining or terminating your coverage under this vision care plan.

Acts of Providers

Blue Cross and Blue Shield is not liable for the acts or omissions by any vision care provider or other provider that furnishes care or services to you. A *preferred vision care provider* or any other vision care provider does not act as an agent on behalf of or for *Blue Cross and Blue Shield*. And, *Blue Cross and Blue Shield* does not act as an agent for a *preferred vision care provider* or any other vision care provider. *Blue Cross and Blue Shield* will not interfere with the relationship between providers and their patients. You are free to select or discharge any provider.

Assignment of Benefits

You cannot assign any benefit or monies due under this Vision Care Policy to any person, corporation, or other organization without *Blue Cross and Blue Shield's* written consent. Any assignment by you will be void. Assignment means the transfer of your rights to the benefits under this vision care plan to another person or organization.

Authorized Representative

You may choose to have another person act on your behalf concerning your benefits under this vision care plan. You must designate this person in writing to *Blue Cross and Blue Shield*. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. In some cases, *Blue Cross and Blue Shield* may consider your vision care provider or other health care provider to be your authorized representative. For example, *Blue Cross and Blue Shield* may tell your vision care provider about the extent of your vision care benefits for services reported. Or, *Blue Cross and Blue Shield* may ask your vision care provider or physician for information if more is needed for *Blue Cross and Blue Shield* to make a decision. *Blue Cross and Blue Shield* will continue to send benefit payments and written communications regarding your vision care benefits according to *Blue Cross and Blue Shield's* standard practices, unless you specifically ask *Blue Cross and Blue Shield* to do otherwise. You can get a form to designate an authorized representative from Member Service.

Changes to this Vision Care Policy

Blue Cross and Blue Shield or your *plan sponsor* may change the provisions of this Vision Care Policy. For example, a change may be made to your cost-sharing amounts for certain *covered services*. When *Blue Cross and Blue Shield* makes a material change to your vision care plan, *Blue Cross and Blue Shield* will send a notice to your *plan sponsor* about the change at least 60 days before the effective date of the change. This notice will describe the change being made. It will also give the effective date of the change. The *plan sponsor* should deliver to its *group members* all notices from *Blue Cross and Blue Shield*.

Coordination of Benefits (COB)

This vision care plan does not include a coordination of benefits provision.

Pre-Existing Conditions

Your benefits are not limited based on medical conditions that are present on or before your effective date in this vision care plan. This means that *covered services* will be covered from your effective date. There is no pre-existing condition restriction or waiting period to receive benefits. But, benefits for *covered services* are subject to all the provisions of your Vision Care Policy.

Quality Assurance Programs

Blue Cross and Blue Shield uses quality assurance and training programs and performance measures that are designed to ensure accuracy in claims processing. *Blue Cross and Blue Shield* also uses management and technology solutions to help Member Service representatives resolve issues quickly and accurately.

Services Furnished by Non-Preferred Vision Care Providers

As a *member* of this vision care plan, you will usually receive the highest benefit level (your in-network benefits) only when you obtain *covered services* from a *preferred vision care provider*. There are a few times when this vision care plan will provide in-network benefits for *covered services* you receive from a non-*preferred vision care provider*. If you receive *covered services* from a non-*preferred vision care provider*, you will receive in-network benefits **only when**:

- You receive emergency care.
- You receive *covered services* that are not reasonably available from a *preferred vision care provider* and you had prior approval from *Blue Cross and Blue Shield* to obtain these *covered services*.

- You receive *covered services* from a covered vision care provider before a preferred network is established for that type of provider.

Subrogation and Reimbursement of Benefit Payments

If you are injured by any act or omission of another person, the benefits provided under this Vision Care Policy will be subrogated. This means that *Blue Cross and Blue Shield* may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If you recover money, *Blue Cross and Blue Shield* is entitled to recover up to the amount of the benefit payments that it has made. This is true no matter where or by whom the recovered money is held or how it is designated and even if you do not recover the total amount of your claim against the other person(s). This is also true if the payment you receive is described as payment for other than vision care expenses. The amount that you must reimburse to *Blue Cross and Blue Shield* will not be reduced by any attorney's fees or expenses that you incur. You must give *Blue Cross and Blue Shield* information and help. This means you must complete and sign all necessary documents to help *Blue Cross and Blue Shield* get this money back. This also means that you must give *Blue Cross and Blue Shield* timely notice of all significant steps during negotiation, litigation, or settlement with any third party (such as filing a claim or lawsuit, initiation of settlement discussions, agreement to a settlement in principle, etc.) and before settling any claim arising out of injuries you sustained by an act or omission of another person(s) for which *Blue Cross and Blue Shield* paid benefits. You must not do anything that might limit *Blue Cross and Blue Shield's* right to full reimbursement.

Time Limit for Legal Action

Before you pursue a legal action against *Blue Cross and Blue Shield* for any claim under this vision care plan, you must complete the *Blue Cross and Blue Shield* formal grievance review. If, after you complete the grievance review, you choose to bring a legal action against *Blue Cross and Blue Shield*, you must bring this action within two years after the cause of the action arises. For example, if you are filing a legal action because you were denied a service or a claim for benefits under this vision care plan, you will lose your right to bring a legal action against *Blue Cross and Blue Shield* unless you file your action within two years after the date of the decision of the final appeal of the service or claim denial. Going through the formal grievance review process does not extend the two-year limit for filing a lawsuit.

Workers' Compensation

No benefits are provided for services or supplies that are furnished to treat an illness or injury that *Blue Cross and Blue Shield* determines was work related. This is the case even if you have an agreement with the workers' compensation carrier that releases them from paying for the claims. All employers provide their employees with workers' compensation or similar insurance. This is done to protect employees in case of a work-related illness or injury. All claims for a work-related illness or injury must be billed to the employer's workers' compensation carrier. It is up to you to use the workers' compensation insurance. If *Blue Cross and Blue Shield* pays for any work-related vision care services or supplies, *Blue Cross and Blue Shield* has the right to get paid back from the party that legally must pay for the claims. *Blue Cross and Blue Shield* also has the right, where possible, to reverse payments made to providers. If you have recovered any benefits from a workers' compensation insurer (or from an employer liability plan), *Blue Cross and Blue Shield* has the right to recover from you the amount of benefits it has paid for your vision care services and supplies. This is the case even if:

- the workers' compensation benefits are in dispute or are made by means of a settlement or compromise;
- no final determination is made that an injury or illness was sustained in the course of or resulted from your employment;

- the amount of workers' compensation due to medical or health care is not agreed upon or defined by you or the workers' compensation carrier; or
- the vision or health care benefits are specifically excluded from the workers' compensation settlement or compromise.

Part 6

Eligibility and Enrollment Provisions

Blue Cross and Blue Shield has entered into an agreement (a group contract) with the *plan sponsor* to provide access to the vision care benefits described in this Vision Care Policy to its eligible *group* employees. The *group* must pay monthly *premiums* to *Blue Cross and Blue Shield* on behalf of its *group members* for this vision care coverage. The *group* should also deliver to its *group members* all notices from *Blue Cross and Blue Shield*. The *group* is the *subscriber's* agent. The *group* is not the agent of *Blue Cross and Blue Shield*. For any enrollment or billing questions, you must contact your *plan sponsor*.

This *group* contract, including this Vision Care Policy and any applicable *riders*, will be governed by and construed according to the laws of the Commonwealth of Massachusetts.

You hereby expressly acknowledge your understanding that the *group* contract constitutes a contract solely between your *group* on your behalf and Blue Cross and Blue Shield of Massachusetts, Inc., which is a corporation independent of and operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting *Blue Cross and Blue Shield* to use the Blue Cross and Blue Shield Service Marks in the Commonwealth of Massachusetts, and that *Blue Cross and Blue Shield* is not contracting as the agent of the Association. You further acknowledge and agree that your *group* on your behalf has not entered into the *group* contract based upon representations by any person other than *Blue Cross and Blue Shield* and that no person, entity, or organization other than *Blue Cross and Blue Shield* will be held accountable or liable to you or your *group* on your behalf for any of *Blue Cross and Blue Shield's* obligations to you created under the *group* contract. This paragraph will not create any additional obligations whatsoever on the part of *Blue Cross and Blue Shield* other than those obligations created under other provisions of the *group* contract.

Eligibility for Group Coverage

Eligible Employee

An employee is eligible to enroll as a *subscriber* for coverage in this vision care plan as long as he or she meets the rules on length of service, active employment, and number of hours worked that the *plan sponsor* has set to determine eligibility for *group* coverage. For details, contact your *plan sponsor*.

Eligible Spouse

The *subscriber* may enroll an eligible spouse for coverage under his or her *group* membership. An "eligible spouse" includes the *subscriber's* legal spouse. A legal civil union spouse, where applicable, is eligible to enroll for coverage under the *subscriber's group* membership to the extent that a legal civil union spouse is determined eligible by the *plan sponsor*. For more details, contact your *plan sponsor*.

Former Spouse

In the event of a divorce or a legal separation, the person who was the spouse of the *subscriber* prior to the divorce or legal separation will remain eligible for coverage under the *subscriber's group* membership, whether or not the judgment was entered prior to the effective date of the *subscriber's group* membership. This coverage is provided with no additional *premium* other than the normal cost of covering a current spouse. The former spouse will remain eligible for this coverage **only** until: the *subscriber* is no longer required by the judgment to provide health care coverage for the former spouse; or the *subscriber* or former spouse remarries, whichever comes first. *Blue Cross and Blue Shield* must be notified within 30 days of a change to the former spouse's address. Otherwise, *Blue Cross and Blue*

Shield will not be liable for any acts or omissions due to having the former spouse's incorrect address on file. If the *subscriber* remarries, the former spouse may continue coverage under a separate membership within the *subscriber's group*, provided the divorce judgment requires that the *subscriber* provide health care coverage for the former spouse. This is true even if the *subscriber's* new spouse is not enrolled for coverage under the *subscriber's group* membership.

Domestic Partner
As determined by the *plan sponsor*, the *subscriber* may have the option to enroll an eligible domestic partner under his or her *group* membership. **To determine if this eligibility option applies to you, you must contact your *plan sponsor*.** A "domestic partner" is a person with whom the *subscriber* has entered into an exclusive relationship. This means that both the *subscriber* and domestic partner: are 18 years of age or older and of legal age of consent in the state where they reside; are competent to enter into a legal contract; share the same residence and must intend to continue to do so; are jointly responsible for basic living costs; are in a relationship of mutual support, caring, and commitment in which they intend to remain; are not married to anyone else; and are not related to each other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which they live. A "domestic partner" may also include a person with whom the *subscriber* has registered as a domestic partner with any governmental domestic registry (whether or not all of the conditions stated above have been met). If the *subscriber* enrolls an eligible domestic partner under his or her *group* membership, the domestic partner's dependent children are eligible for coverage to the same extent that the *subscriber's* dependent children are eligible for coverage under his or her *group* membership. If the *subscriber* terminates the domestic partnership, an enrolled former domestic partner (and any enrolled children of a former domestic partner) may have the option to continue *group* coverage to the extent that federal or Massachusetts law would usually apply.

Eligible Dependents

The *subscriber* may enroll eligible dependents for coverage under his or her *group* membership. "Eligible dependents" include the *subscriber's* or spouse's (or if applicable, legal civil union spouse's or domestic partner's) children until the end of the calendar month in which the child turns age 26. To be an eligible dependent, a child under age 26 is not required to: live with the *subscriber* or spouse (or if applicable, legal civil union spouse or domestic partner); or be a dependent on the *subscriber's* or spouse's (or if applicable, legal civil union spouse's or domestic partner's) tax return; or be a full-time student. These eligible dependents may include:

- A newborn child. The effective date of coverage for a newborn child will be the child's date of birth provided that the *subscriber* formally notifies the *plan sponsor* within 30 days of the date of birth.
- An adopted child. The effective date of coverage for an adopted child will be the date of placement of the child with the *subscriber* for the purpose of adoption. The effective date of coverage for an adoptive child who has been living with the *subscriber* and for whom the *subscriber* has been getting foster care payments will be the date the petition to adopt is filed. If the *subscriber* is enrolled under a family membership as of the date he or she assumes custody of a child for the purpose of adoption, the child's dental benefits will be provided from the date of custody. This coverage is provided without a waiting period or pre-existing condition restriction.
- A newborn infant of an enrolled dependent child immediately from the moment of birth and continuing after, until the enrolled dependent child is no longer eligible as a dependent.

If an eligible dependent child is married, the dependent child can enroll for coverage under the *subscriber's group* membership. And, as long as that enrolled child is an eligible dependent, his or her children are also eligible for coverage under the *subscriber's group* membership. The dependent child's spouse is **not** eligible to enroll as a dependent for coverage under the *subscriber's group* membership.

An eligible dependent may also include:

- A person under age 26 who is not the *subscriber's* or spouse's (or if applicable, legal civil union spouse's or domestic partner's) child but who qualifies as a dependent of the *subscriber* under the Internal Revenue Code. In this case, when the dependent loses his or her dependent status under the Internal Revenue Code, that dependent will continue to be eligible as a dependent under the *subscriber's group* membership for two years after the end of the calendar year in which he or she last qualified as a dependent under the Internal Revenue Code or until the dependent turns age 26, whichever comes first.
- A child recognized under a Qualified Medical Child Support Order as having the right to enroll for health care coverage.
- A disabled dependent child age 26 or older. A dependent child who is mentally or physically incapable of earning his or her own living and who is enrolled for coverage under the *subscriber's group* membership will continue to be covered after he or she would otherwise lose dependent eligibility under the *subscriber's group* membership, so long as the child continues to be mentally or physically incapable of earning his or her own living. In this case, the *subscriber* must make arrangements with *Blue Cross and Blue Shield* through the *plan sponsor* not more than 30 days after the date the child would normally lose eligibility. Also, *Blue Cross and Blue Shield* must be given any medical or other information that it may need to determine if the child can maintain coverage under the *subscriber's group* membership. From time to time, *Blue Cross and Blue Shield* may conduct reviews that will require a statement from the attending physician. This is to confirm that the child is still an eligible disabled dependent child.

Important Reminder: The eligibility provisions for dependents that are described in this section may differ from the federal tax laws that define who may qualify as a dependent.

Enrollment Periods for Group Coverage

Initial Enrollment

You may enroll for coverage in this vision care plan on your initial *group* eligibility date. This date is determined by your *plan sponsor*. The *plan sponsor* is responsible for providing you with details about how and when you may enroll for coverage under a *group* membership. To enroll, you must complete the enrollment form provided by your *plan sponsor* no later than 30 days after your eligibility date. (For more information, contact your *plan sponsor*.) If you choose not to enroll for coverage in this vision care plan on your initial eligibility date, you may enroll only during your *group's* open enrollment period or within 30 days of a special enrollment event as provided by federal or Massachusetts law.

Special Enrollment

If an eligible employee or an eligible dependent (including the employee's spouse) chooses not to enroll for coverage in this vision care plan on his or her initial *group* eligibility date, federal or Massachusetts law may allow the eligible employee and/or his or her eligible dependents to enroll when:

- The employee and/or his or her eligible dependents have a loss of other coverage (see "Loss of Other Qualified Coverage" below); or
- The employee gains a new eligible dependent (see "New Dependents" below); or
- The employee and/or his or her eligible dependent become eligible for assistance under a Medicaid plan or a state Children's Health Insurance Program plan.

These rights are known as your "special enrollment rights." There may be additional special enrollment rights as a result of changes required by federal law. For example, these changes may include special enrollment rights for: individuals who are newly eligible for coverage as a result of changes to dependent

eligibility; and/or individuals who are newly eligible for coverage as a result of the elimination of a lifetime maximum.

Loss of Other Qualified Coverage
An eligible employee may choose not to enroll himself or herself or an eligible dependent (including a spouse) for coverage in this vision care plan on the initial *group* eligibility date because he or she or the eligible dependent has other health plan coverage as defined by federal law. This is referred to as "qualified" coverage. In this case, the employee and the eligible dependent may enroll for coverage in this vision care plan if the employee or the eligible dependent at a later date loses that other qualified health plan coverage due to any one of the following reasons:

- The employee or the eligible dependents (including a spouse) cease to be eligible for the other qualified health plan. For example, this could mean that the loss of the other qualified health plan was due to: the loss of the spouse's coverage; the death of the spouse; divorce; loss of dependent status; or involuntary termination. This includes when an employee or eligible dependent is covered under a Medicaid plan or a state Children's Health Insurance Program plan and coverage is terminated as a result of loss of eligibility for that coverage.
- The employer that is sponsoring the other qualified group health plan coverage ceases to make employer contributions for the other group health plan coverage.
- The employee or the eligible dependents (including a spouse) exhaust their continuation of group coverage under the other qualified group health plan.
- The prior qualified health plan was terminated due to the insolvency of the health plan carrier.

Important Note: You will **not** have this special enrollment right if the loss of other health plan coverage is a result of the eligible employee or the *subscriber* or the eligible dependent's failure to pay the applicable premiums.

New Dependents
If an eligible employee gains a new spouse or other new eligible dependent(s) due to marriage, adoption, placement for adoption, or birth, the employee and the spouse and/or the new dependent(s) may enroll for coverage in this vision care plan. If the new dependent is gained by birth, adoption, or placement for adoption, enrollment in this vision care plan will be retroactive to the date of birth or the date of adoption or the date of placement for adoption. But, the time requirement described below must be met.

Special Enrollment Time Requirement
To exercise your special enrollment rights, you must notify your *plan sponsor* no later than 30 days after the date when any one of the following events occur: the date you lose your other coverage; the date the *subscriber* gains a new dependent; the date the *subscriber* receives notice that a dependent child who was not previously eligible is newly eligible for coverage as a result of changes to dependent eligibility; or the date you receive notice that you are newly eligible for coverage as a result of the elimination of a lifetime maximum. For example, if your coverage under another health plan is terminated, you must notify your *plan sponsor* and request enrollment within 30 days after your other health care coverage ends. Upon request, the *plan sponsor* will send you any special forms you may need. If you do not request enrollment within 30 days, you will have to wait until the *group's* next open enrollment period to enroll for *group* coverage. You also have special enrollment rights related to termination of coverage under a state Children's Health Insurance Program plan or a Medicaid plan or eligibility for assistance under a Medicaid plan or a state Children's Health Insurance Program plan. When this situation applies, you must notify your *plan sponsor* to request *group* coverage in this vision care plan no later than 60 days after the coverage terminates or the employee or eligible dependent is determined to be eligible for assistance.

Qualified Medical Child Support Order
If the *subscriber* chooses not to enroll an eligible dependent for coverage under his or her *group* membership in this vision care plan on the initial *group* eligibility date, the *subscriber* may be required by law to enroll the dependent if the *subscriber* is subject to a Qualified Medical Child Support Order (QMCSO). This QMCSO order is a state court or administrative agency order that requires an employer's *group* to provide coverage to the child of an employee who is covered or eligible to enroll for *group* coverage.

Open Enrollment Period

If you choose not to enroll for *group* coverage in this vision care plan within 30 days of your initial *group* eligibility date, you may enroll during your *group's* open enrollment period. The open enrollment period is the time each year during which eligible persons may enroll for or change coverage for the next year. The open enrollment period is announced by the *group* to all eligible employees. To enroll for *group* coverage in this vision care plan during this enrollment period, you must complete the enrollment form provided in the *group's* enrollment packet and return it to the *group* no later than the date specified in the *group's* enrollment packet.

Other Membership Changes

Generally, the *subscriber* may make membership changes (for example, change from a *subscriber* only membership to a family membership) only if the *subscriber* has a change in family status. This includes a change such as: marriage or divorce; birth, adoption, or change in custody of a child; death of an enrolled spouse or dependent; or the loss of an enrolled dependent's eligibility under the *subscriber's group* membership. **If you want to ask for a membership change or you need to change your name or mailing address, you should call or write to your *plan sponsor*.** The *plan sponsor* will send you any special forms that you may need. You must request the change within the time period required by the *subscriber's group* to make a change. If you do not make the change within the required time period, you will have to wait until the *group's* next open enrollment period to make the change. All changes are allowed only when they comply with the eligibility and enrollment rules set by the *plan sponsor* for *group* coverage and they comply with the conditions outlined in this Vision Care Policy.

Part 7
Termination of Coverage

Loss of Eligibility for Group Coverage

When your eligibility for *group* coverage, your coverage in this vision care plan will be terminated as of the date you lose *group* eligibility. Your eligibility for coverage in this vision care plan ends when:

- The *subscriber* loses eligibility with the *group* for coverage in this vision care plan. This means: the *subscriber's* hours are reduced; or the *subscriber* leaves the job; or the *subscriber* no longer meets the rules that are set by the *group* for coverage in this vision care plan. You will also lose eligibility for *group* coverage in this vision care plan if you are an enrolled dependent when the *subscriber* dies.
- You lose your status as a dependent under the *subscriber's* membership in this vision care plan.
- The *plan sponsor* fails to pay the *group premium* to *Blue Cross and Blue Shield* within 30 days of the due date. In this case, *Blue Cross and Blue Shield* will notify you in writing of the termination of your coverage in this vision care plan in accordance with the Code of Massachusetts Regulations. This notice will give you information about the termination of your coverage in this vision care plan.
- The *group* terminates (or does not renew) its *group* contract with *Blue Cross and Blue Shield.*

Termination of Coverage by the Subscriber

Your coverage in this vision care plan will end when the *subscriber* chooses to cancel his or her membership as permitted by the *plan sponsor*. *Blue Cross and Blue Shield* must receive the termination request not more than 30 days after the *subscriber's* termination date.

Termination of Coverage by Blue Cross and Blue Shield

Your coverage in this vision care plan will not be canceled because you are using your benefits or because you will need more *covered services* in the future. *Blue Cross and Blue Shield* will cancel your coverage in this vision care plan **only when**:

- You have committed misrepresentation or fraud to *Blue Cross and Blue Shield*. For example, you gave false or misleading information on the enrollment form. Or, you misused your ID card by letting another person who was not enrolled for coverage in this vision care plan attempt to get benefits. In this case, the termination of your coverage in this vision care plan may go back to your effective date or, it may go back to the date of the misrepresentation or fraud. The termination date will be determined by *Blue Cross and Blue Shield*, subject to applicable federal law. Or, in some cases *Blue Cross and Blue Shield* may limit your benefits.
- You commit acts of physical or verbal abuse that pose a threat to health care and vision care providers or to other members of *Blue Cross and Blue Shield* or Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., and these acts are not related to your physical condition or mental condition. In this case, termination of your coverage in this vision care plan will follow the procedures approved by the Massachusetts Commissioner of Insurance.
- You fail to comply in a material way with any provisions of this vision care plan. For example, if you fail to provide information that *Blue Cross and Blue Shield* requests related to your coverage in this vision care plan, *Blue Cross and Blue Shield* may terminate your vision care plan.
- *Blue Cross and Blue Shield* discontinues this vision care plan for any reason as of a date approved by the Massachusetts Commissioner of Insurance.

If *Blue Cross and Blue Shield* cancels your coverage in this vision care plan, a notice will be sent to your *group* that will tell your *group* the specific reason(s) that *Blue Cross and Blue Shield* is canceling your coverage in this vision care plan.

Part 8
Continuation of Group Coverage

Limited Extension of Group Coverage under State Law

If you lose eligibility for *group* coverage due to a plant closing or a partial plant closing (as defined by law) in Massachusetts, you may continue *group* coverage as provided by state law. If this happens to you, you and your *group* will each pay your shares of the *premium* cost for up to 90 days after the plant closing. Then, to continue your *group* coverage for up to 39 more weeks, you will pay 100% of the *premium* cost. At this same time, you may also be eligible for continued *group* coverage under other state laws or under federal law (see below). If you are, the starting date for continued *group* coverage under all of these laws will be the same date. But, after the 90-day extension period provided by this state law ends, you may have to pay more *premium* to continue your *group* coverage. If you become eligible for coverage under another employer sponsored health plan at any time before the 39-week extension period ends, continued *group* coverage under these provisions also ends.

Continuation of Group Coverage under Federal or State Law

When you are no longer eligible for *group* coverage, you may be eligible to continue *group* coverage as provided by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or under Massachusetts state law. These provisions apply to you if your *group* has two or more employees. To continue your *group* coverage, you may be required to pay up to 102% of the *premium* cost. These laws apply to you if you lose eligibility for *group* coverage due to one of the following reasons.

- Termination of employment (for reasons other than gross misconduct).
- Reduction of work hours.
- Divorce or legal separation.
  (In the event of divorce or legal separation, a spouse is eligible to keep coverage under the employee's *group* membership. This is the case only until the employee is no longer required by law to provide health care coverage for the former spouse or the employee or former spouse remarries, whichever comes first. The former spouse's eligibility for continued *group* coverage will start on the date of divorce, even if he or she continues coverage under the employee's *group* membership. While the former spouse continues coverage under the employee's *group* membership, there is no additional *premium*. After remarriage, under state and federal law, the former spouse may be eligible to continue *group* coverage under a separate *group* membership for an additional *premium* cost.)
- Death of the *subscriber*.
- *Subscriber's* entitlement to Medicare benefits.
- Loss of status as an eligible dependent.

The period of this continued *group* coverage begins with the date of your qualifying event. And, the length of this continued *group* coverage will be up to 36 months from that qualifying event. This is true except for termination of employment or reduction of work hours, in which cases continued *group* coverage is available for only 18 months or, if you are qualified for disability under Title II or Title XVI of the Social Security Act, up to 29 months. (See below for more information about continued coverage for disabled employees.) You should contact your *plan sponsor* for more help about continued coverage.

When a *subscriber's* legal same-sex spouse (or if applicable, civil union spouse or domestic partner) is no longer eligible for coverage under the *subscriber's group* membership, that spouse (or if applicable, that civil union spouse or domestic partner) and his or her dependents may continue coverage in the

subscriber's group to the same extent that a legal opposite-sex spouse and his or her dependents could continue *group* coverage upon loss of eligibility for *group* coverage.

Additional Continued Group Coverage for Disabled Employees

At the time of the employee's termination of employment or reduction in hours (or within 60 days of the qualifying event under federal law), if an employee or his or her eligible dependent is determined to be disabled under Title II or Title XVI of the Social Security Act, continued *group* coverage will be available for up to 29 months from the date of the qualifying event. The *premium* cost for the additional 11 months may be up to 150% of the *premium* rate. If during these 11 months eligibility for disability is lost, *group* coverage may cancel before the 29 months is completed. You should contact your *plan sponsor* for more help about continued *group* coverage.

Special Rules for Retired Employees

A retired employee, the spouse, and/or eligible dependent children of a retired employee or a surviving spouse of a retired deceased employee who loses eligibility for *group* coverage as a result of a bankruptcy proceeding (Title 11 of the United States Code) is also eligible to continue *group* coverage as provided by COBRA or under Massachusetts state law. A retired employee and/or the surviving spouse of a deceased retired employee may enroll for lifetime continued *group* coverage as of the date of the bankruptcy proceeding, provided that the loss of *group* eligibility occurs within one year before the date on which the bankruptcy proceeding begins. Or, if *group* eligibility is lost within one year after the date on which the bankruptcy proceeding begins, they may enroll for lifetime continued *group* coverage as of the date *group* eligibility is lost. Spouses and/or eligible dependents of these retired employees may enroll for continued *group* coverage until the retired employee dies. Once the retired employee dies, his or her surviving spouse and/or eligible dependents may enroll for up to an additional 36 months of continued *group* coverage beyond the date of the retired employee's death. Lifetime continued *group* coverage for retired employees will end if the *group* cancels its agreement with *Blue Cross and Blue Shield* to provide its *group members* with *group* coverage or for any of the other reasons described below in "Termination of Continued Group Coverage."

Enrollment for Continued Group Coverage

To enroll for continued *group* coverage, you must complete an Election Form. The completed election form must be returned to the office at the address on the form. The form must be returned within 60 days from your date of termination of *group* coverage or your notification of eligibility, whichever is later. If you do not return the completed form, it will be considered a waiver. And, you will not be allowed to continue *group* coverage. (The 60 days will be counted from the date of the eligibility notice to the postmarked date of the mailed election form.)

Termination of Continued Group Coverage

Your continued *group* coverage will end when:

- The length of time allowed for continued *group* coverage is reached (for example, 18 months or 29 months or 36 months from the qualifying event).
- You fail to make timely payment of your *premium* costs.
- You enroll in another employer sponsored health plan and that plan does not include pre-existing condition limitations or waiting periods.
- You become entitled to Medicare benefits.
- You are no longer disabled (if your continued *group* coverage had been extended because of disability).

- The *group* terminates its agreement with *Blue Cross and Blue Shield* to provide its *group members* with access to vision care benefits under this Vision Care Policy. In this case, *group* coverage may continue under another health plan. Contact your *plan sponsor* for more information.

Part 9

Explanation of Terms

The following words are shown in italics in this Vision Care Policy, your *Schedule of Vision Care Benefits*, and any *riders* that apply to your coverage in this vision care plan. The meaning of these words will help you understand your vision care benefits.

Allowed Charge (Allowed Amount)

The maximum reimbursement amount for a specific *covered service* that is used to calculate your cost-sharing amounts and payment of your vision care benefits. It is the dollar amount assigned for a *covered service* based on various pricing mechanisms. In most cases when you use a *preferred vision care provider* for *covered services*, you do not have to pay the amount of the *preferred vision care provider's* actual charge that is in excess of the *allowed charge*. But when you use a non-*preferred vision care provider* for *covered services*, you will have to pay the amount of the vision care provider's actual charge that is in excess of the *allowed charge*.

Balance Billing

There certain times when a vision care provider will bill you for the difference between his or her charge and the *allowed charge*. This is called *balance billing*.

Blue Cross and Blue Shield

Blue Cross and Blue Shield of Massachusetts, Inc. This includes an employee or designee of *Blue Cross and Blue Shield* who is authorized to make decisions or take action called for in this Vision Care Policy.

Copayment

The cost you may have to pay for a *covered service* (your cost-sharing amount). A *copayment* is a fixed dollar amount. In most cases, a *preferred vision care provider* will collect the *copayment* from you at the time the *covered service* is furnished. But, when the vision care provider's actual charge at the time of furnishing the *covered service* is less than your *copayment*, you pay only the vision care provider's actual charge. Any later charge adjustment—up or down—will not affect your *copayment* or the cost you were charged at the time of the service if it was less than the *copayment*. Your *Schedule of Vision Care Benefits* shows your *copayment* amount for *covered services*.

Covered Services

The vision care services covered by your vision care plan and for which *Blue Cross and Blue Shield* will provide benefits as described in this Vision Care Policy and your *Schedule of Vision Care Benefits*.

Group

The corporation, partnership, individual proprietorship, or other organization that has an agreement for *Blue Cross and Blue Shield* to provide its enrolled *group members* with access to vision care benefits as described in this Vision Care Policy, including your *Schedule of Vision Care Benefits*. The group should deliver to its *group members* notices from *Blue Cross and Blue Shield*. The *group* is your agent and is not the agent of *Blue Cross and Blue Shield*.

Member
A person who is enrolled and eligible for coverage in this vision care plan. A *member* may be the *subscriber* or his or her enrolled eligible spouse or any other enrolled eligible dependent.

Preferred Vision Care Provider
An ophthalmologist, optometrist, optician, or other vision care practitioner who has a written payment agreement with, or has been designated by, *Blue Cross and Blue Shield* to provide vision care services to *members* enrolled in this vision care plan. These vision care providers are also referred to as "in-network" vision care providers.

Plan Sponsor
The *plan sponsor* is usually your employer and is the same as the plan sponsor designated under the Employee Retirement Income Security Act of 1974, as amended (ERISA). If you are not sure who your *plan sponsor* is, you should ask the *subscriber's* employer.

Premium
The monthly cost of your coverage that must be paid by your *group* to *Blue Cross and Blue Shield*. Your *premium* may change from time to time. Each time *Blue Cross and Blue Shield* changes your *premium*, *Blue Cross and Blue Shield* will notify your *group* on your behalf before the change takes place.

Rider
Blue Cross and Blue Shield or your *group* may change the terms of your vision care plan. If a material change is made to your Vision Care Policy, it is described in a *rider*. For example, a *rider* may add to or limit the benefits provided by your vision care plan. *Blue Cross and Blue Shield* will supply you with *riders* (if there are any) that apply to your vision care benefits. You should keep these *riders* with this Vision Care Policy and your *Schedule of Vision Care Benefits* so that you can refer to them.

Schedule of Vision Care Benefits
This Vision Care Policy includes a *Schedule of Vision Care Benefits*. It describes the services that are covered by your vision care plan and the cost-sharing amounts you must pay for each *covered service*. **Be sure to read all parts of this Vision Care Policy and your *Schedule of Vision Care Benefits* so you can understand your vision care benefits.** You should be sure to read the descriptions of *covered services* and the limitations and exclusions that are described in Part 1 of this Vision Care Policy and in your *Schedule of Vision Care Benefits*.

Subscriber
The eligible employee who signs the enrollment form at the time of enrollment in this vision care plan.

Utilization Review
The review process that is used to evaluate the medical necessity and appropriateness of a vision care service. This process is designed to encourage appropriate care, not less care. To develop clinical guidelines and *utilization review* criteria, each service is assessed to determine that it is: consistent with the prevention and treatment of vision conditions; consistent with standards of good vision care practice; and as cost effective as any established alternative. Periodically, clinical guidelines and review criteria are updated to reflect new treatments, applications, and technologies.