

PCI Insurance, Inc.



This booklet has been prepared so that you may become acquainted with your Pennsylvania Blue Shield OptiChoice® program available to active *employees* who are eligible and enrolled for it. The benefits described are subject to the terms of the group contract issued by Pennsylvania Blue Shield (known as the Plan).

The amount of benefits for any *covered service* will not be more than the amount charged by the vision provider and will not be greater than any *maximum* amount or limit described or referred to in this booklet.

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How to Use This Booklet

How to Use This Booklet

This booklet contains pertinent information about your OptiChoice Program, including covered and non-covered services, program limitations, etc.

The section titled "General Information" includes important information about COBRA (continuation coverage), claims filing information, etc.

The "Definitions of Terms" section is a resource designed to help you better understand the terminology used to describe specific elements of your coverage. All words defined in the "Definitions of Terms" are printed in *bold italics* wherever they appear in the text.

General Information

General Information

Dependents Eligible for Enrollment

Your spouse and all unmarried children under 19 years of age (including stepchildren, children legally placed for adoption and your and your spouse's legally adopted children) who are continuously financially supported by you, or whose coverage is your or your spouse's responsibility under the terms of a release or court order, are eligible for enrollment. Unmarried **dependent** children in full-time attendance at an accredited secondary school, college or university, may be included up to age 23.

Upon application to and acceptance by Pennsylvania Blue Shield, you may also include unmarried, **dependent** children 19 years of age or older who are incapable of self-support due to a physical or mental handicap which occurred prior to age 19, and who were eligible for coverage as **dependents** prior to age 19.

Each person included under your coverage is entitled, separately, to the benefits described in this booklet, except where noted otherwise.

Newborn Dependent Provision

Benefits are available for a newborn child of a **member** for 31 days immediately following birth.

This benefit does not include routine well-baby care, immunizations and medical examinations or tests not necessary for the treatment of a covered injury, sickness or condition, except to the extent dependency coverage is provided under the contract. To continue coverage beyond this period, application must be made by the **member** within 31 days after birth, and the appropriate rate must be paid when billed.

Changes in Your Address or Family Status

It is important that you notify our office promptly of any change in your address or your family status--including marriage, divorce, birth or adoption of a child, marriage of **dependent** children, death of spouse or child.

How OptiChoice Benefits are Obtained

Preferred Provider

Present your Pennsylvania Blue Shield OptiChoice Identification Card at the time services are provided by a **Preferred Provider** or **Contracting Supplier**. The Identification Card will identify your eligibility for Vision Care PPO benefits. A window decal will be displayed in the Provider's office locations which identifies participation in the OptiChoice Program. If you receive services or products from a **Preferred Provider** or **Contracting Supplier**, you will have all or a portion of your bill paid by the Program, since **Preferred Providers** and **Contracting Suppliers** agree to accept the billed charge, the Program Allowance, or their charge, whichever is less, as payment in full for professional services and standard post-refractive products. The **Preferred Provider** or **Contracting Supplier** will submit claim forms to Blue Shield on your behalf.

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Non-Preferred Provider

If you go to a *non-preferred provider* or *non-contracting supplier*, you must pay the doctor directly for all charges, or pay any portion of the bill not covered by Blue Shield. Non-preferred providers are not required to submit claim forms to Blue Shield.

If you have to submit a claim yourself, you must do so within one year from the date of service. Request an itemized bill which shows:

- (1) patient's name and address
- (2) date of service
- (3) type of service and diagnosis
- (4) itemized charges
- (5) *professional provider's* complete name and address

Then add the *member's* name, group and identification numbers (as shown on your identification card), and the patient's birthdate. If you need assistance, call Pennsylvania Blue Shield at **1-800-541-2039**. If you do not need assistance, please send your receipt to:

Pennsylvania Blue Shield
P.O. Box 890500
Camp Hill, PA 17089-0500

Release of Information

Any person or entity having information relating to an illness or injury for which benefits are claimed under your coverage by you or your enrolled *dependent* may furnish to Blue Shield, upon its request, any information (including copies of records relating to the illness or injury).

In addition, Blue Shield may furnish similar information to other entities providing similar benefits at your request.

Blue Shield shall provide to your employer at the employer's request certain information regarding claims and charges submitted to Blue Shield. This information will be adjusted to prevent the disclosure of the identity of *members* who are treated by providers.

Coordination of Benefits

Blue Shield Plan

In addition to this program's broad scope of benefits the program has a Coordination of Benefits provision. The purpose of this provision is to conserve funds associated with vision care. Coordination of Benefits is applicable only when you, your spouse or your *dependent(s)* are eligible for benefits under more than one group vision plan.

When you receive vision care services that are also covered under another plan, a determination is made as to which plan is "primary" and which plan is "secondary". The primary plan considers the services without regard to the secondary plan. The secondary plan will then consider the balances on *covered services* according to the limitations of its program.

If the plan is determined to be the secondary plan, Blue Shield will not pay more than they would have, had there been no other coverage.

The primary plan will be determined in the following order:

1. If the other plan does not include a provision to coordinate benefits, it will be the primary plan.

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2. If the other plan does include a provision to coordinate benefits then:
 - A. The plan covering the patient as the *employee/member* is the primary plan.
 - B. Except for situations where the parents of a child are separated or divorced, the plan of the parent whose date of birth (month, day) falls earlier in the calendar year is the primary plan for that child. If both parents have the same birth date, the plan which covered the parent longer shall be primary.

Note: In the event this plan is coordinating with a plan that uses a rule based on the gender of the parent, benefits will be coordinated as follows:

Except for situations where the parents of a child are separated or divorced, the plan of the male parent is primary.

- C. In those situations where the parents are separated or divorced, the primary plan is determined as follows:
 - 1) the plan covering the parent with custody of the child is primary
 - 2) if the parent with custody of the child has remarried, the stepparent's plan will pay for covered services before the plan of the parent without custody
 - 3) a court decree may determine the primary plan. You should advise your employer of any court decree.
 - D. When the determination cannot be made with the above rules, then the plan that has covered the patient for the longer period of time will be the primary plan, except:

...the plan which covers the patient as an active *employee/member* (or a *dependent* of such a person) is the primary plan over a plan that covers a patient as a laid-off or retired person (or a *dependent* of such a person).

...if either plan does not have this condition then it does not apply and the plan which has been in effect the longer period of time is primary.
3. If services are provided under a governmental program for which the *member* pays a periodic rate, that program is the primary plan, except when prohibited by law or when the *member* elects Medicare as secondary coverage.

Blue Shield may pay their benefits first and determine liability later. If it is determined that this program is the secondary plan, Blue Shield has the right to recover the expense already paid in excess of their liability as the secondary plan. If the other health care plan is the primary plan, Blue Shield may limit payment so that Blue Shield will not pay more than the difference, if any, between the primary plan's payment and the charge. Benefits payable under another plan include benefits that would have been payable had the claim been duly made. When this program is determined to be primary, but payment was made by another plan, Blue Shield has the right to reimburse the other plan, the amount which Blue Shield determines is its liability.

Blue Shield may release to or obtain from any person or organization, any information about coverage, expenses and benefits which may be necessary to coordinate benefits. The *employee* on his/her own behalf and on behalf of their *dependent(s)* may be required to furnish information and to take such other action as is necessary to assure the rights of Blue Shield.

Termination of Coverage

When your eligibility terminates, all benefits of this program will end.

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Continuation of Coverage Provisions - Consolidated Omnibus Budget Reconciliation Act of 1985, As Amended (COBRA)

This may or may not apply to your group. Please contact your employer to find out whether or not you are covered under this provision.

For purposes of this subsection of your booklet, “qualified continuee” means any person who, on the day before any event which would qualify him or her for continuation under this subsection, is covered for group health benefits under this Plan as:

- a. you, an active, covered *employee*;
- b. your spouse; or
- c. your *dependent* child.

In addition, any child born to or placed for adoption with you during COBRA continuation will be a qualified continuee.

Any person who becomes covered under this Plan during COBRA continuation, other than a child born to or placed for adoption with you during COBRA continuation, will not be a qualified continuee.

If An Employee Terminates Employment or Has a Reduction of Work Hours

If your group benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if:

- a. your termination of employment was not due to gross misconduct; and
- b. you are not entitled to Medicare.

The continuation will cover you and any other qualified continuee who loses coverage because of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, subject to the “**When Continuation Ends**” paragraph of this subsection.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the day before the qualified continuee's health benefits would otherwise end due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours or within 60 days of that date, the qualified continuee and any other affected qualified continuees may elect to extend the 18 month continuation period described above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Plan Administrator must be given written proof of Social Security’s determination of the qualified continuee’s disability before the earlier of:

- a. The end of the 18 month continuation period; and
- b. 60 days after the date the qualified continuee is determined to be disabled.

If, during the 11 month continuation period, the qualified continuee is determined to be no longer disabled under the United States Social Security Act, the qualified continuee must notify the Plan Administrator within 30 days of such determination, and continuation will end, as explained in the “**When Continuation Ends**” paragraph of this subsection.

If an Employee Dies

If you die, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the “**When Continuation Ends**” paragraph of this subsection.

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If an Employee's Marriage Ends

If your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the “**When Continuation Ends**” paragraph of this subsection.

If an Employee Becomes Entitled to Medicare

If you become entitled to Medicare *after* terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months from the date the initial 18 month continuation period started, subject to the “**When Continuation Ends**” paragraph of this subsection.

If you become entitled to Medicare *before* terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours and, during the subsequent 18-month period, you terminate employment (for reasons other than gross misconduct) or have a reduction of work hours, all qualified continuees other than you whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 18 months, but may be extended until 36 months from the date you became entitled to Medicare, subject to the “**When Continuation Ends**” paragraph of this subsection.

If a Dependent Loses Eligibility

If your *dependent* child's group health benefits end due to his or her loss of *dependent* eligibility as defined in this booklet, other than your coverage ending, he or she may elect to continue such benefits. However, such *dependent* child must be a qualified continuee. The continuation can last for up to 36 months, subject to the “**When Continuation Ends**” paragraph of this subsection.

Concurrent Continuations

If your *dependent* who is a qualified continuee elects to continue his or her group health benefits due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours, the *dependent* may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period the *dependent* becomes eligible for 36 months of group health benefits due to any of the reasons stated above.

The 36 month continuation period starts on the date the initial 18 month continuation period started, and the two continuation periods will run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this subsection must notify the Plan Administrator, in writing, of:

- a. your legal divorce or legal separation from your spouse; or
- b. your *dependent* child's loss of *dependent* eligibility, as defined in this booklet.

The notice must be given to the Plan Administrator within 60 days of either of these events.

In addition, a disabled qualified continuee must notify the Plan Administrator, in writing, of any final determination that the qualified continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act. The notice must be given to the Plan Administrator within 30 days of such final determination.

The Employer's Responsibilities

Your Employer must notify the Plan Administrator, in writing, of:

- a. your termination of employment (for reasons other than gross misconduct) or reduction of work hours;

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- b. your death; or
- c. your entitlement to Medicare.

The notice must be given to the Plan Administrator within 60 days of any of these events.

The Plan Administrator's Responsibilities

The Plan Administrator must notify the qualified continuee, in writing, of:

- a. his or her right to continue the group health benefits described in this booklet;
- b. the monthly premium he or she must pay to continue such benefits; and
- c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

- a. the date the Employer notifies the Plan Administrator, in writing, of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, your death, or your entitlement to Medicare; or
- b. the date the qualified continuee notifies the Plan Administrator, in writing, of your legal divorce or legal separation from your spouse, or your *dependent* child's loss of eligibility.

The Employer's Liability

Your Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in the place of, the Plan, if:

- a. the Employer fails to remit a qualified continuee's timely premium payment to the Plan on time, thereby causing the qualified continuee's group health benefit to end; or
- b. the Plan Administrator fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Plan Administrator written notice that he or she elects to continue benefits under the coverage. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Plan Administrator as described above or 60 days of the date the qualified continuee's group health benefits end, if later. Furthermore, the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Plan Administrator by the qualified continuee, 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 continuee stayed insured under this benefit plan on a regular basis. It includes any amount that would have been paid by the Employer. An additional charge of two percent of the total premium charge may also be required by the Employer.

Qualified continuees who receive the extended coverage due to disability described above may be charged an additional 50% of the total premium charge during the extra 11 month continuation period.

If the qualified continuee fails to give the Plan Administrator notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

General Information

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee 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 continuee's continued group health benefits under this coverage ends on the first to occur of the following:

- a. with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- b. with respect to a disabled qualified continuee and his or her family members who are qualified continuees who have elected an additional 11 months of continuation, the earlier of:
 - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
 - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;
- c. with respect to continuation upon your death, your legal divorce or legal separation, or the end of your covered *dependent's* eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- d. with respect to your *dependent* whose continuation is extended due to your entitlement to Medicare,
 - *after* your termination of employment or reduction of work hours, the end of the 36 month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours; and
 - *before*, your termination of employment or reduction of work hours where, during the 18-month period following Medicare entitlement, you terminate employment or have a reduction of work hours, at least to the end of the 18 month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours, but not less than 36 months from the date you become entitled to Medicare.
- e. the date this coverage ends;
- f. the end of the period for which the last premium payment is made;
- g. the date he or she 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 continuee other than a pre-existing condition exclusion or limitation which he or she satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
- h. the date he or she becomes entitled to Medicare.

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

General Information

THE PLAN IS NOT THE PLAN ADMINISTRATOR UNDER THE COVERAGE 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.

Vision Program

The Pennsylvania Blue Shield

OptiChoice® Program



Who is eligible to render services under the OptiChoice program?

- **Professional Providers** who are licensed doctors of medicine or osteopathic medicine including a specialist in ophthalmology (Ophthalmologist), or a licensed doctor of optometry (Optometrist).
- Suppliers who are engaged in dispensing ophthalmic lenses, (e.g. contact lenses and/or eyeglass lenses) in accordance with a prescription written by a **Professional Provider**, which includes opticians and retail optical dispensing firms.

Payment for Professional Services

Payment for covered eye examination and refractive services and contact lens evaluation and fitting is made on the basis of the **Provider's Reasonable Charge** (the charge that Blue Shield determines is reasonable for **covered services** provided to a **member**). The **Provider's Reasonable Charge** will be the Program Allowance or the billed charge, whichever is lowest.

Blue Shield payments for professional services determined according to the above criteria are accepted as payment-in-full by a **Preferred Provider**. For services of a non-**Preferred Provider**, Blue Shield makes payment on the same basis, however, payment is made directly to the **member**.

Payment for Post-Refractive Services

Payment for post-refractive products will be made directly to the **Preferred Providers** and **Contracting Suppliers** furnishing the **covered services**.

A. Eyeglasses

1. Frames

Contracting Suppliers and Preferred Providers agree to accept the lower of the **program allowance** or the amount charged as payment-in-full for frames which have a charge of \$60 or less. If the **member** chooses frames with a charge over \$60, the **member** is responsible at the point of purchase for the difference between \$60 and the charge.

2. Lenses

Contracting Suppliers and Preferred Providers agree to accept the lower of the **program allowance** or the amount charged as payment-in-full for standard lenses. If the **member** chooses nonstandard lenses, the **member** is responsible for 90% of the difference between the charge for standard lenses and the charge for nonstandard lenses. Nonstandard lenses are those that have, as part of their manufacturing process, been provided with features that enhance their desirability to consumers. Such lenses include, but are not limited to, polycarbonate lenses and progressive “no-line” bifocals. This differential payment must be made at the point of purchase. **Contracting Suppliers and Preferred Providers** agree to accept these payments -- the program allowance plus the differential payment -- as payment-in-full for nonstandard lenses.

Vision Program

B. Contact Lenses

Contracting Suppliers and **Preferred Providers** agree to accept the lower of the **program allowance** or the amount charged as payment-in-full for standard contact lenses. If the **member** chooses specialty contact lenses, the **Contracting Supplier** or **Preferred Provider** agrees to accept the **program allowance** as payment-in-full for lenses that have a charge of \$75 or less. The **member** is responsible at the point of purchase for the difference between \$75 and the charge for the specialty lenses. Specialty lenses include, but are not limited to, hard or soft bifocal, hard or soft toric, soft extended wear, and gas permeable. An unlimited number of disposable contact lenses (up to \$75) are eligible throughout the benefit period. Payment for eyeglasses or contact lenses obtained from a **non-Contracting Supplier** or **non-Preferred Provider** will be made to the **member** on the basis of the **program allowance** or the amount charged, whichever is less. Such payment constitutes full discharge of Blue Shield's responsibility under the program. The **member** is responsible for payment of the remaining charge.

Either one pair of eyeglass lenses *or* one pair of standard or specialty contact lenses, *or* unlimited number of disposable contact lenses (up to \$75) are eligible within the benefit period.

Benefits

Eye Examination and Refractive Services

Eye examination and refractive services include, but are not limited to, the following:

- Case History;
- Visual acuities, near and distance;
- External examination, including pupils, motilities, color vision test (when indicated), etc.;
- Tonometry;
- Refraction, subjective, objective;
- Binocular vision testing when indicated;
- Slit Lamp Examination of the anterior segment including the crystalline lens;
- Fundus examination, including dilated fundus exam when indicated;
- Assessment; and
- Plans.

Contact Lens Evaluation and Fitting

A separate examination, also rendered by a licensed ophthalmologist or optometrist, for the purpose of fitting and prescribing contact lenses is also covered. Such services, performed by a **professional provider**, shall include, but are not necessarily limited to:

- Keratometry;
- Proper fitting of appropriate contact lenses, including the application of trial contact lenses to the patients' corneas;
- Training of a new contact lens wearer;
- Post-dispensing contact lens follow-up care, including the correction of any ill-fitting or unsuitable lenses, for a period of 90 days.

Post-Refractive Services

Post-refractive services consist of:

- Ordering lenses and frames (facial measurement, lenticular formula, and other specifications)
- Cost of the materials
- Verification of the completed prescription upon return from the laboratory
- Adjustment of the completed glasses
- Subsequent servicing (refitting, realigning, readjusting, tightening) for a period not to exceed 90 days.

Vision Program

OptiChoice Reimbursement

Benefit	In-Network Coverage	Out-of-Network Reimbursement
Eye Examination and Refraction	Paid-in-full	\$32
Frames	Paid-in-full (up to \$60 retail)	\$24
Eyeglass Lenses per pair		
<i>Standard Lenses</i>		
Single Vision	Paid-in-full	\$24
Bifocal	Paid-in-full	\$36
Trifocal	Paid-in-full	\$46
Aphakic/Lenticular	Paid-in-full	\$72
<i>Specialty Lenses</i> (such as photochromatic, polycarbonate or progressive 'no line' bifocals)	You pay 90% of the difference between the provider's full charge for specialty and standard lenses	Reimbursement as listed above, except for progressive lenses which are reimbursed at \$41
Contact Lens Evaluation and Fitting		
Daily Wear	Paid-in-full	\$20
Extended Wear	Paid-in-full	\$30
Contact Lenses per pair		
<i>Standard</i> (Hard/Soft Daily Wear Spherical)	Paid-in-full	\$48
<i>Specialty</i> (including but not limited to: Extended Wear, Hard/Soft Bifocal, Gas Permeable)	Paid-in-full (up to \$75 value)	\$48
<i>Disposables</i> (unlimited lenses)	Paid-in-full (up to \$75 throughout the benefit period)	\$75
Lens Options (Tints, Coatings) Vision Care Supplies	10% Discount	Not Covered
Additional Eyewear and Examinations (excluding disposable contacts)	You pay only the Out-of-Network Reimbursement which is accepted as payment in full for all standard products ¹	Not Covered

¹ OptiChoice providers accept \$24 as payment in full for frames priced up to \$60 and \$48 as payment in full for contact lenses priced up to \$75.

Vision Program

Limitations

Payment for *covered services* will be limited in the following manner:

1. Payment for frames, lenses and/or contact lenses, supplied by a Supplier, will be made only if prescribed by a **Professional Provider**.
2. Payment for an eye examination and refraction is limited to once every 12 months for *members* under 19 years of age and once every 24 months for *members* 19 years of age and older.
3. Payment for contact lens evaluation and fitting is limited to once every 12 months for *members* under 19 years of age and once every 24 months for *members* 19 years of age and older.
4. Payment for lenses or contact lenses is limited to once every 12 months for *members* under 19 years of age and once every 24 months for *members* 19 years of age and older.
5. Regardless of the age of the *member*, payment is limited to one set of frames in any 24 month period.
6. Eligibility will be determined from the date of the last previous similar service recorded under this Agreement or any other Pennsylvania Blue Shield Vision Agreement for this group.
7. Group *members* may use their coverage for either contacts or eyeglasses; however, OptiChoice will not cover the cost of purchasing both contact lenses and eyeglass lenses within the same *benefit period*. In addition to traditional frames and lenses, frames and lenses for prescription sunglasses, prescription safety glasses and prescription athletic lenses may also be purchased in lieu of traditional frames and lenses.

Additional Savings

In circumstances where the services or products are covered, but exceed the frequency limitations outlined above, **Contracting Suppliers** and **Preferred Providers** agree to furnish services or products at discounted prices (excluding disposable contacts) provided payment is made by the *member* at the point of purchase.

Preferred Providers' Special Sale or Package Prices

Preferred Providers are not obligated to accept the OptiChoice *program allowance* when the *member* elects their special sale or package price. The provider will still submit the claim, however, the *member* is required to pay the entire sale or package price at the point of purchase. The *member* will then be reimbursed directly from Pennsylvania Blue Shield the out-of-network reimbursement for covered services.

NOTE: This does not affect the 10% discount on vision care options. The 10% discount is in addition to, and not in lieu of any other special promotions and/or sale prices.

Vision Exclusions - What is Not Covered

Except as specifically provided in this booklet, you are not covered for services, supplies or charges that:

- are the cost of any insurance premiums indemnifying against losses for lenses or frames;
- are 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 any legislation of any governmental unit. This exclusion applies whether or not you claim the benefits or compensation;
- are provided by any governmental unit;
- you would have no legal obligation to pay in the absence of this or any similar coverage;
- are 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;
- are performed prior to the *effective date*;
- are incurred after your termination date except for lenses and frames prescribed prior to such termination and delivered within 31 days from such date;
- are not billed by the **Professional Provider** or **Contracting Supplier**;
- the cost of which has been or is later recovered in any action or law or in compromise or settlement of any claim except where prohibited by law;
- are 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;

Vision Program

- are to the extent payment has been made under Medicare when Medicare is primary or payment would have been made if the *member* had applied for Medicare and claimed Medicare Benefits;

You are not covered for:

- medical or surgical treatment of the eye;
- procedures determined by Blue Shield to be special or unusual, such as but not limited to, orthoptics, vision training, subnormal vision aids, and tonography;
- examinations or materials which are not listed herein as a covered service or item of supply;
- any lenses which do not require a prescription;
- replacement of lost, stolen, broken or damaged lenses, contact lenses or frames unless the frequency limitations are met;
- non-prescription industrial safety glasses and safety goggles;
- eye examinations or materials necessitated by employment or furnished as a condition of employment;
- telephone consultations, charges for failure to keep a scheduled appointment, or charges for completion of a claim form;
- temporary devices, appliances, and services;
- services in which the *member* incurs no charge;
- duplicate devices, appliances and services;
- treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insured plan;
- diagnostic services, such as diagnostic x-rays, cardiographic, encephalographic examinations and pathological or laboratory tests;
- drugs or any other medications;
- any other service or treatment except as provided in this booklet.

Definition of Terms

Definition of Terms

For the purposes of this booklet, the terms below have the following meaning.

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 Plan.

CONTRACTING SUPPLIER - a Supplier who has an agreement with the Plan pertaining to payment for *covered services* rendered to a *member*. Contracting Suppliers are not *professional providers*.

COVERED SERVICE - a service or supply specified in this booklet for which benefits will be provided when rendered by a *professional provider* or supplier.

DEPENDENT - an *employee's* spouse and unmarried children who meet the eligibility requirements outlined in the "General Information" section of this booklet.

EFFECTIVE DATE - the date on which coverage for a *member* begins.

EMPLOYEE - an individual of the group who meets the eligibility requirements for enrollment, who is so specified for enrollment, and in whose name the identification card is issued.

FAMILY COVERAGE - coverage for the *employees* 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.

LIMITATIONS - the *maximum* frequency or age at which a *covered service* is allowed.

MAXIMUM - the greatest amount payable by the Plan for *covered services*. This could be expressed in dollars, number of days, or number of services for a specified period of time.

MEMBER – an enrolled *employee* and his or her eligible *dependents* who have satisfied the specifications of eligibility.

NON-CONTRACTING SUPPLIER - a supplier of vision hardware that does not participate in the Plan's managed vision care programs.

NON-PREFERRED PROVIDER - a *professional provider* who does not participate in the Plan's managed vision care program and is not required to accept the Plan's payment as payment in full for professional services.

PREFERRED PROVIDER - a *professional provider* who has an agreement with the Plan pertaining to payment for *covered services* rendered to a *member* enrolled in the Plan's Preferred Provider managed vision care programs.

PRESCRIBED DATE - the date the prescription was written to the laboratory for the service.

Definition of Terms

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

PROGRAM ALLOWANCE - a schedule of allowances as established by Pennsylvania Blue Shield and approved by the Insurance Department of the Commonwealth of Pennsylvania.

PROVIDER'S REASONABLE CHARGE - the charge that the Plan determines is reasonable for *covered services* provided to a *member*. The Provider's Reasonable Charge is the *program allowance* or the charge, whichever is lower.

Claims Appeal Procedure

Claims Appeal Procedure

If your claim has been denied in whole or in part, you will be notified by Pennsylvania Blue Shield. This rejection letter will set forth the specific reasons for such denial. If you wish to appeal this decision, you may write to your company's employee benefits department or write directly to the address which appears on the rejection letter (marked to the attention of the person, if any, who signed the letter).

First, however, it is important for you to understand the reasons for the denial of benefits in order to decide whether you want to appeal and request that the claim be reviewed again. You should examine your group agreement, which is on file with your employer. The group agreement is a legal document setting forth the full terms and conditions of your professional coverages and excluded services. You may request a fuller explanation of the rejection decision by calling 1-800-541-2039.

You may appeal a denial of benefits within 60 days of the date of the rejection by sending a letter stating why you think your claim should not have been denied, including a copy of the denial letter and any additional claim. Be sure to include in your letter your group number, your identification number, claim number, if any, your employer's name and the date of service for which benefits were denied.

Please send your appeal to:

Pennsylvania Blue Shield
P.O. Box 890500
Camp Hill, PA 17089-0500

Upon receipt of your letter and any additional information you provide, your records will be reviewed; and the results of this review will be sent to you normally within 60 days. In unusual cases, as when review of your claim requires examination by qualified medical personnel, including consulting, the physicians review may take longer than 60 days.

Customer Service Information

Customer Service Information

We all have questions about our vision care coverage from time to time. To help you get accurate answers to questions and up-to-date information about your vision plan, we have included this section.

Call the department or person who handles benefits for your organization first, whenever you have questions about your coverage program. If you still have questions, call Vision Customer Service at 1-800-541-2039. The Customer Service Representatives have all the current information about your vision care coverage at their fingertips.

When you call, give the representative your identification number (printed on your Blue Shield identification card), so he or she can access information about your coverage.

For information available through the Internet, please visit:

Clarity Vision, Inc.
www.clarityvision.com

Clarity Vision, a Highmark Company, administers the Pennsylvania Blue Shield vision benefits.