# WEA Select Vision Plan C

## Benefit Book

**Underwritten by Premera Blue Cross**
**Administered by Vision Service Plan**

PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

vsp Vision care for life

AON

WEA WASHINGTON EDUCATION ASSOCIATION SELECT

010391 (10-2010) Vision Plan C

# How to Contact Us

## Customer Service Contacts

***Mailing Address***
Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105

## For more information go to

***www.vsp.com***

- Personalized benefit information
- Provider directory

***www.premera.com/wea***

- Benefit books
- Summary of benefits

***WEA Plan Consultant:***

**Aon Consulting**
1420 Fifth Ave., Suite 1200
Seattle, WA 98101-4030
206-467-4646

# BENEFITS SUMMARY

Below is a brief description of your in- and out-of-network vision benefits. Please see “Benefits Details” for additional information.

As noted below, enrollees pay:

- Copays for exams and materials (frames, eyeglass lenses, contact lenses) and
- All charges exceeding any allowable amount or benefit maximum

| Benefits | VSP Participating Providers | Other Licensed Vision Providers |
|---|---|---|
| **Copays** | | |
| Exam | $5.00 | $5.00 |
| Materials | $15.00 | $15.00 |
| **Examination**<br>**Once each calendar year after copay** | Paid in Full | $60.00 |
| **Eyeglass Lenses (pair)**<br>**Once each calendar year after copay** | | |
| Single Vision | Paid in Full | $76.00 |
| Bifocal | Paid in Full | $112.00 |
| Trifocal | Paid in Full | $142.00 |
| Lenticular | Paid in Full | $148.00 |
| Continuous Blend Lenses | Paid in Full | $140.00 |
| Lens Tinting, Coating or Oversized Lenses* | Paid in Full | Not Covered |
| **Frames**<br>**Once each 2 calendar years after copay** | $110.00 | $60.00 |
| **Contact Lenses (including disposables**)**<br>**Once each 2 calendar years after copay (in lieu of frames and eyeglass lenses)** | $200.00 | $200.00 |
| **Medically Necessary*****<br>**Contact Lenses**<br>**Once each 2 calendar years after copay (in lieu of frames and eyeglass lenses)** | Covered in full after prior approval | 316.00 |

**Please Note:**

**Contact lenses may be purchased in lieu of frames and eyeglass lenses, once each two calendar years. If benefits for contact lenses are obtained under the plan, no benefits for eyeglass lenses or frames will be available for two calendar years. The annual examination benefit will still be available.**

**Charges for vision services or supplies that exceed what is covered under this plan are not covered under benefits of your WEA Select Medical Plan.**

*Includes progressives, polycarbonates or photochromic lenses

**Any number of disposable contact lenses are covered up to the maximum benefit for contact lenses during each 2 calendar years.

***Please contact VSP at 1-800-877-7195 with any questions.

# WEA SELECT VISION PLAN C

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# INTRODUCTION

Your WEA Select Vision Plan was designed specifically for school employees in Washington by the Washington Education Association (WEA) in cooperation with Aon Consulting (benefit consultant), and Premera Blue Cross in collaboration with Vision Service Plan (VSP).

The WEA is the policyholder for this plan of vision benefits. The WEA retains full and exclusive authority, at its discretion, to determine the availability of this plan. The plan is not guaranteed to continue indefinitely. The plan may be altered or terminated at any time.

The WEA Benefits Services Advisory Board reviews all plan benefits and limitations and they are approved by the WEA Board of Directors. Your suggestions for plan improvements are always welcome and may be forwarded to the WEA or Aon Consulting.

**To understand how your benefits are paid, please review this booklet when you enroll.** As vision expenses are incurred, you may wish to review the section which applies to those specific types of expenses.

Call Vision Service Plan (VSP) at the following number if you have questions on coverage or claims:

Toll-Free: 1-800-877-7195
Hearing Impaired TDD: 1-800-428-4833

**Throughout the booklet, we use many terms that have specific meaning under this plan. The terms "you" and "your" refer to the enrollees under this plan. The terms "we," "us," and "our" refer to Premera Blue Cross.**

Contract Form Number: ..... 1223C

# WHO IS COVERED AND WHEN

Applications must be completed upon initial enrollment or within 60 days for newly acquired dependents.

## EMPLOYEE COVERAGE

You are eligible if you are an employee of a participating employer group and employed as an employee of any division of the Washington Public Schools, or the WEA and its affiliates.

The participating employer group pays the subscription charges for this coverage. All full-time employees, as defined by the participating employer group, must enroll, regardless of any other vision coverage under any other plan. This coverage requirement includes the employee and any eligible dependent(s) who may have vision coverage from another source.

Coverage begins on the first of the month following the date of eligibility, if subscription charges are remitted on a timely basis.

## AGE 65/CONTINUING EMPLOYMENT AS AN ACTIVE EMPLOYEE

If you are either an active employee or an active employee's covered spouse and are age 65 or over, this WEA Select Vision Plan will provide primary coverage and your Medicare coverage will be secondary. See also "Effect of Medicare."

## DEPENDENT COVERAGE

Dependents will have the same effective date as you (except those acquired after the effective date), provided you have made proper application.

Eligible dependents are:

- The lawful spouse.
- The domestic partner of the subscriber. All rights and benefits afforded to a “spouse” under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term “establishment of the domestic partnership” shall be used in place of “marriage”; the term “termination of the domestic partnership” shall be used in place of “legal separation” and “divorce.”

  **Please Note:** Domestic partnerships that are **not** documented in a state registry must meet all requirements as stated in the signed “WEA Select Health Plans Declaration of Domestic Partnership.” To obtain a copy of this form, please visit www.premera.com/wea and click on Forms.
- The children up to age 26. ("Children" includes the subscriber's or spouse's natural child, adopted child, or child placed with the subscriber in accordance with state law for the purpose of legal adoption. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child.)

  A child age 26 or older incapable of self support due to a physical or developmental disability is an eligible dependent when all of the following requirements are met:
  - The child is incapable of self-sustaining employment due to a developmental disability or physical handicap and is chiefly dependent upon the subscriber for support and maintenance.
  - You complete a Request for Certification of Handicapped Dependent form. We must approve the request for certification. If you are requesting continuation of coverage for a disabled child past age 26, you must provide the certification form to us within 31 days of the child reaching the limiting age. **An overage disabled child who is enrolling on the same date as you are also requires our approval.** You must provide proof of continuous group coverage for the disabled dependent. **Please Note:** You and the disabled child must maintain concurrent coverage under this plan.
  - You provide us with proof of the child’s disability and dependent status when we request it. We will not ask for proof more often than once a year after the two-year period following the child’s 26th birthday.
- A legally placed ward of the subscriber or spouse living permanently in the home of the subscriber. There must be a court order signed by a judge, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible dependent.

## MARRIAGE

You must apply within 60 days of marriage to add a newly acquired spouse and children. Upon timely receipt of the completed enrollment application, coverage will begin on the first day of the first of the month following the

date of marriage.

## NATURAL NEWBORN CHILDREN

Children of you or your spouse born while you are covered under this plan are covered from date of birth if enrolled within 60 days of birth. They will receive the same vision benefits as other dependents. An enrollment application isn't required; however, you must notify the plan and we may request additional information if necessary to establish eligibility of the dependent child.

Newborns will be automatically covered for three weeks following the date of birth when the mother is enrolled on this plan.

## ADOPTIVE CHILDREN

Children placed for adoption with the subscriber on or after your effective date are covered from the date of placement if enrolled for coverage within 60 days of placement. An enrollment application isn't required; however, you must notify the plan and we may request additional information if necessary to establish eligibility of the dependent child.

Please contact the WEA Select Service Team at 1-800-932-9221 for information on the appropriate documents needed to add your newly adopted child.

## LEGAL GUARDIANSHIP/NON-PARENTAL CUSTODY

Children under legal guardianship (legal wards) or under a legal non-parental custody decree may be enrolled for coverage if the following conditions are met:

- The legal guardianship/non-parental custody was awarded in accordance with the laws of the state in which it was obtained. Documentation must be provided, including the court order and petition for guardianship/non-parental custody, stating the reason and authority of the guardianship/non-parental custody. When the court order terminates or expires, the child is no longer an eligible dependent.
- The guardian/person with non-parental custody is either you or your spouse. The guardian/person with non-parental custody and the child must both be enrolled under the same plan.
- The child is under the age of 26.
- The child has been placed in your home under a parent-child relationship.
- The guardian/person with non-parental custody provides the main support for the child, outside of federal or state support.

When a completed enrollment application is received for an eligible child covered under legal guardianship (legal wards) or under a legal non-parental custody decree within 60 days of the date of that decree, coverage required under the decree will become effective on the date of the decree.

## MEDICAL CHILD SUPPORT ORDERS

When a child is to be added to your coverage due to a medical child support order, we must receive a copy of the court order (or National Medical Support Notice, Part A or Part B) with the completed enrollment application. When we receive these documents within 60 days of the date of notice, coverage for the eligible child required under the order becomes effective on your coverage as of the date of notice.

If we do not receive these documents within the 60-day time period, coverage under your plan will be effective on the first of the month after we receive the order and application. The application may be submitted by you, the child's custodial parent, a state agency administering Medicaid, or the state child support enforcement agency.

## MEDICAL ASSISTANCE AND CHILDREN'S HEALTH INSURANCE PROGRAM

Employees and dependents who are eligible as described in "Who Is Covered And When" have special enrollment rights under this plan if one of the statements below is true:

- The person who is eligible for state medical assistance, and the Washington State Department of Social and Health Services (DSHS) determines that it is cost-effective to enroll the person in this plan.
- The person qualifies for premium assistance under the state's medical assistance program or Children's Health Insurance Program (CHIP).
- The person no longer qualifies for health coverage under the state's medical assistance program or CHIP.

**To be covered, the eligible employee or dependent must apply and any required subscription charges must be paid no more than 60 days from the date the applicable statement above is true.** Coverage will start on the first of the month following the date we receive the application for coverage. An eligible employee who elected not to enroll in this plan when such coverage was previously offered, must enroll in this plan in order for any otherwise eligible dependents to be enrolled in accordance with this provision. Coverage for the employee will start on the date the dependent's coverage starts. In order to apply for coverage, you may be required to provide the notice of eligibility you received from DSHS.

### CHANGE IN DEPENDENT STATUS

If the number of your family members changes, please request a new application form, fill it out, include all eligible dependents, and return it to your Payroll Office within 30 days following the change in status.

If the status of family members changes due to death, attainment of age 26, or divorce, please notify your Payroll Office within 60 days. Premera Blue Cross/VSP will have the right to recover benefits paid in error.

When a family member is no longer eligible on your group coverage, he or she may continue coverage through COBRA (see section "Continuation of Group Coverage - COBRA").

If you or your dependent becomes eligible for Medicare, please notify your Payroll Office within 60 days in order to learn how your benefits are affected.

## CONTINUED ENROLLMENT: SELF-PAY PROVISIONS

### LEAVE OF ABSENCE

Coverage for you and any enrolled dependents on an official leave of absence or sabbatical may continue for up to 18 months. The leave of absence time period must begin at the end of the last month of coverage paid from fringe benefit funds earned during active employment. If you do not elect continued coverage at this time, or if you terminate coverage at any time during the leave of absence, you must re-enroll on the plan within 30 days of your return to active employment. If you do not elect coverage under the leave of absence provision, or terminate coverage during the leave, you will immediately become eligible for COBRA. To be eligible for COBRA, you must elect coverage under COBRA within 60 days after coverage ends under the leave of absence provision.

**A district-approved leave beyond 18 months does not entitle you (or your enrolled dependents) to extend coverage under this leave of absence provision.** If the leave extends beyond this 18 months of continued coverage, you and your enrolled dependents may be eligible for an additional 18 months of continued coverage through COBRA (see below). If you do not return to work after the leave or if another consecutive district-approved leave is granted without another period of active employment, "COBRA" will also be available.

The maximum period of extended coverage under any circumstance is 36 months, i.e., up to 18 months of continued coverage under the leave of absence provision and up to 18 months of COBRA continuation coverage.

Additional coverage under this provision may be elected if you return to work and are granted further official leaves of absence or sabbaticals.

Example:

- You are granted a leave of absence and are no longer actively at work as of March 20
- Your active work results in fringe benefit dollars for March, which pay for April benefits
- You will receive sick leave through the district leave-sharing plan for 2 months

In the above example, the 18-month leave of absence coverage period would officially begin on May 1, because April is the last month of fringe benefit funds from active employment. The total extended coverage for sick leave and the leave of absence would be 18 months, at which time the district would need to provide you notice of access to COBRA continuation for 18 additional months (total 36 months). If the above leave of absence started before the March payroll cutoff for benefits, the leave period would begin April 1.

Dependents may not be added while you are covered during this time; however, newly acquired dependents may be added if they meet the eligibility and enrollment requirements of this plan.

### FAMILY AND MEDICAL LEAVE

You may be entitled to continue coverage under the Family and Medical Leave Act of 1993. Please contact your Human Resource Department for further information.

## LABOR DISPUTE

If compensation is suspended directly or indirectly as a result of strike, lockout or other labor dispute, you may pay subscription charges for yourself and eligible dependents directly to the employer for up to six months. See "Continuation of Group Coverage - COBRA" for continued health care coverage when the six-month period ends. This period of coverage will not extend any other period of continued coverage provided by the plan.

When your compensation or wage is suspended or terminated, you will be notified immediately in writing by your participating employer group. A notice will be mailed to the address last on record with your participating employer group that you may pay subscription charges to the participating employer group as noted in this section.

## REDUCTION IN FORCE

For those participating employer groups who do not provide COBRA coverage this plan may be continued on a self-paid basis through the group for up to 12 months from the date of lay-off (see section "Continuation of Group Coverage - COBRA.")

## CONTINUATION UNDER USERRA

The Uniformed Services Employment And Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights on employer-provided health care coverage) of individuals who voluntarily or involuntarily leave employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are re-employed.

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

## CONTINUATION OF GROUP COVERAGE - COBRA

When group coverage is lost because of a "qualifying event" outlined below, federal laws and regulations require the participating employer group to offer an election to continue the group coverage for a limited time. (These laws and regulations are referred to in this plan as "COBRA.") Continued coverage is not automatic. Under COBRA, a qualified enrollee must apply for continued coverage within a certain time period and may also have to pay the subscription charges for it.

The participating employer group must fulfill all of the obligations and responsibilities regarding continued coverage that are assigned by COBRA to the participating employer group, plan sponsor or administrator, and to the group health plan. Neither Premera Blue Cross nor VSP is the COBRA plan administrator, and our actions pertaining to COBRA continued coverage under this contract shall not be construed as relieving the participating employer group of its responsibility under COBRA. We provide coverage only to the extent that enrollees are entitled to continued coverage under COBRA and only to the extent of the other terms and limitations of this contract.

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

**Qualifying Events and Length of Coverage:** Please contact the participating employer group immediately when one of the qualifying events below occurs. The continuation periods listed extend from the date of the qualifying event.

**Please Note:** Covered domestic partners and their children have the same rights to COBRA coverage as covered spouses and their children.

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

However, if one of the events listed above follows the covered employee's entitlement to Medicare by less than 18 months, the participating employer group must offer the covered spouse and children an election to continue coverage for up to 36 months starting from the date of the Medicare entitlement.

COBRA coverage can be extended if an enrollee who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.

- The participating employer group must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of one of four qualifying events:
  - The subscriber dies
  - The subscriber and spouse legally separate or divorce
  - The subscriber becomes entitled to Medicare
  - A child loses eligibility for dependent coverage

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

**Conditions Of Continued Coverage:** For continued coverage to become effective, all of the requirements below must be met:

### You Must Give Notice Of Some Qualifying Events

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

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

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

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

  Note: You or your affected dependent must also notify the group if a qualified enrollee is deemed by the Social Security Administration to no longer be disabled. See "When COBRA Coverage Ends."
- For the other events above, the 60-day notice period starts on the **later** of: 1) the date of the qualifying event, or 2) the date the qualified enrollee would lose coverage as a result of the event.

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

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

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

### You Must Enroll And Pay On Time

- The enrollee must elect continued coverage no more than 60 days after the **later** of: 1) the date coverage was to end because of the qualifying event, or 2) the date the participating employer group notified the enrollee of his or her right to elect continued coverage.

  Each qualified enrollee will have an independent right to elect COBRA coverage. Subscribers may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.
- The enrollee must send the first subscription charge payment to the participating employer group no more than 45 days after the date the person elected continued coverage.
- Subsequent subscription charges must be paid on a timely basis to the participating employer group and submitted to Premera Blue Cross with the participating employer group's regular monthly billings.

### Adding Family Members

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

### Keep the participating employer group informed of address changes

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

### When COBRA Coverage Ends

Continued coverage will end on the last day for which subscription charges have been paid in the monthly period in which the first of the following occurs:

- The applicable continuation period expires.
- The next monthly subscription charge is not paid when due or within the grace period.
- If the enrollee has extended COBRA coverage due to disability, it will end if Social Security determines that the person is no longer disabled. In this case, coverage terminates at the end of the month that begins at least 30 days after Social Security's decision. For example, if Social Security decides on March 15 that the enrollee is not disabled, coverage would end May 31. The enrollee must provide the participating employer group a copy of the determination within 30 days after the **later** of: 1) the date of the determination or 2) the date on which you or your affected dependent was informed that this notice should be provided and given procedures to follow.
- The enrollee becomes covered under another group health care plan after the date COBRA coverage was elected. If, however, the new plan contains an exclusion or limitation for a pre-existing condition, coverage does not end for this reason until the exclusion or limitation no longer applies.
- The enrollee becomes entitled to Medicare after the date COBRA coverage was elected.
- The participating employer group ceases to offer this WEA Select Vision plan to any employee in the bargaining unit/employee classification. However, the enrollee should contact the participating employer group regarding participation in any other group health plan offered to the bargaining unit/employee classification.

**However, even if one of the events above has not occurred, continued coverage under this plan will end on the date that the contract between the WEA and Premera Blue Cross is cancelled.**

### If You Have Questions

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

## WHEN YOUR COVERAGE ENDS

Coverage for the subscriber and all dependents under this vision plan will stop at the end of the period for which the appropriate subscription charges were paid, or if one of the following occurs:

Subscriber And Dependents:

- The subscriber ceases to meet the eligibility requirements
- The subscriber is no longer employed by or connected with the participating employer group, or the participating employer group no longer participates in this plan
- The next monthly subscription charge is not paid when due or within the grace period
- The contract between the WEA and Premera Blue Cross is cancelled

Spouse:

- His or her marriage to the subscriber terminates due to divorce or annulment or, if earlier, when the subscriber is no longer legally responsible for covered expenses incurred by the spouse
- The subscriber dies or is no longer covered under this plan

Dependent Child(ren):

- Reaches the age of 26 (unless developmentally disabled or physically handicapped - See "Who Is Covered And When")
- Marries
- The subscriber dies or is no longer covered under this plan

If the subscriber is no longer employed by or eligible for coverage with the participating employer group or a family member is no longer eligible, coverage will be cancelled automatically without notice at the end of the period for which subscription charges have been appropriately paid. **Refunds will not exceed more than 60 days worth of subscription charges, based on the date a change is reported to us**. See "Continuation of Group Coverage - COBRA" for continued benefits.

## PROGRAM TRANSFERS

### TRANSFER PROVISION

In the event an enrollee transfers from one WEA Select Vision plan to another, any benefits paid under the prior plan will be applied to this plan's benefit maximums.

### CONTRACT REPLACEMENT

When the contract, of which this plan is a part, replaces another contract between the WEA and us with no lapse in coverage, amounts credited toward your benefit maximums under the other plan will also apply to this plan's benefit maximums.

# HOW YOUR PLAN WORKS

## YOUR ENROLLEE ID CARD

When you go to your vision care provider, please give the provider your enrollee ID number. You received this number in a letter from Premera Blue Cross after you enrolled on the plan. If you do not have it, you may contact VSP Customer Service for your enrollee ID number.

## SELECTING A PROVIDER

### Services From A Participating VSP Provider

- Select a VSP participating provider from the VSP Participating Provider Directory online or call VSP Customer Service at 1-800-877-7195 to receive one and make an appointment.
- Pay the VSP participating provider the copays for eyeglass lenses and/or selected frames or contact lenses. You must also pay the VSP participating provider additional charges if you choose items with limited coverage under the plan or that are not reimbursable under the plan.
- The VSP participating provider will itemize any charges that are not covered. Sign the form to document that you received services. The VSP participating provider will return the form and be paid directly.

### Services From A Nonparticipating Provider

If covered vision care services are received from a nonparticipating provider, it will be your responsibility to submit your claim to VSP. This procedure is described in the "How to Submit A Vision Claim" below.

You will be responsible for all charges which exceed your plan's scheduled amounts for covered services, and for services and supplies not covered by your vision care plan.

# HOW TO SUBMIT A VISION CLAIM

You may select any licensed vision care provider; however, enhanced benefits are **only** available when a VSP participating provider is selected.

If you use a nonparticipating provider, you will need to submit the claim yourself. Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the eye examination, lens type and frame. Send a copy of the itemized bill(s) to VSP. The following information must also be included in your documentation:

- Enrollee's name and mailing address
- Enrollee's identification number
- Enrollee's employer or group name
- Patient's name, relationship to employee and date of birth

You may submit the above information on a HCFA-1500 form or any generic insurance claim form that may be available from your non-participating provider upon request.

Please mail the itemized bill(s) and form to the following address:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105

### Timely Filing of Claims

Please submit all claims within 90 days from the start of service or within 30 days after the service is completed. **We will not provide benefits for claims we receive after 12 months from the date of service.**

Be sure your group and subscriber identification numbers are shown on all bills or correspondence.

# BENEFIT DETAILS

Benefits are available to covered enrollees for the vision services and supplies described in this section when the services and supplies meet all of these requirements:

- They must be prescribed and furnished by a covered vision care provider
- They must be named as covered under this plan
- They must not be excluded from coverage under this plan

Note: Charges for vision services or supplies that exceed what is covered under this plan are not covered under benefits of your WEA Select Medical Plan.

## COVERED SERVICES AND SUPPLIES

This section describes the specific benefits available for covered vision services and supplies when a VSP participating provider is utilized.

## PAYMENT FOR SERVICES

The vision benefits of this plan are based on allowable charges for covered services and supplies. The allowable charge is the fee that the **participating** vision care provider agrees to accept as full payment from us for necessary covered services, except for frames and contact lenses. The enrollee is responsible for any charges in excess of this plan's benefit maximums and for services or supplies not covered under this plan.

The enrollee is responsible for the following expenses:

- Copays for exams and materials (frames, eyeglass lenses, contact lenses) and
- Any fees that exceed the allowable charge or are in excess of stated benefit maximums and
- Charges for services and supplies not covered under this plan

Please see the summary at the beginning of the book for copay amounts and benefit maximums for covered services and supplies from **nonparticipating** vision care providers.

Please refer to the "Definitions" section for a more detailed explanation of allowable charge.

## EXAMINATIONS

Your plan provides one routine vision examination per enrollee each calendar year after a copay. Covered routine examination services include:

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

## LENSES

If benefits for contact lenses are obtained under the plan, no benefits for eyeglass lenses or frames will be available for two calendar years. The annual examination benefit will still be available.

Please see the summary at the beginning of the book for copay amounts and the frames benefit maximum for participating and nonparticipating providers.

- **Eyeglass lenses once each calendar year:** Your plan provides up to two eyeglass lenses per enrollee.

  Benefits for the following are included in the maximum benefit for the type of lens prescribed:

  - Lens tinting or coating
  - Fitting of eyeglass lenses to frames
- **Contact lenses in lieu of frames and lenses once every two calendar years:** Your plan will provide up to two contact lenses and includes the contact lens fitting to the eyes.

  Any number of disposable contact lenses are covered up to the maximum benefit for contact lenses during every 2 calendar years.
- **Medically necessary contact lenses in lieu of frames and lenses once every two calendar years:** Your

plan provides up to two medically necessary contact lenses in lieu of eyeglass lenses and frames. Please contact VSP at 1-800-877-7195 with questions about medically necessary contact lenses.

## FRAMES

Your plan provides one pair of frames per enrollee each two consecutive calendar years.

When you purchase frames from a participating vision care provider, you are covered up to $110 for your frame allowance. If you choose a frame that exceeds this plan allowance, you will receive a 20% discount on the overage.

Please see the summary at the beginning of the book for copay amounts and the frames benefit maximum for participating and nonparticipating providers.

## ADDITIONAL DISCOUNTS

### Eyeglass Lenses and Frame

VSP offers you even more value by providing a 30% discount on additional pairs of prescription glasses, sunglasses, nonprescription sunglasses and lens options from the same VSP doctor on the same day as your vision exam. You may receive 20% off from any VSP doctor within 12 months of your vision exam.

### Contact Lenses

VSP's additional value is also extended to include a 15% discount off the participating provider's professional fees when you purchase prescription contact lenses. This benefit is available in conjunction with your VSP contact lens allowance, or you can use it to purchase contacts in addition to glasses.

**You may use these discounts for 12 months following the date of the covered eye examination from any VSP provider.**

# WHAT YOUR VISION PLAN DOES NOT COVER

## Exclusions And Limitations

## Exclusions

Your plan **does not** cover any services or supplies furnished in connection with the following conditions, services or supplies:

1. Vision services received from a:
   - Vision or medical department maintained for employees by or on behalf of an employer; or
   - Mutual benefit association, labor union, trustee or similar person or group.
2. Facility charges for vision procedures.
3. Military and war related conditions, including illegal acts

   This includes:
   - Acts of war, declared or undeclared, including acts of armed invasion.
   - Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto.
   - An enrollee's commission of an act of riot or insurrection.
   - An enrollee's commission of a felony or act of terrorism.
4. Any service or supply which is experimental or investigational on the date it is furnished based on the criteria stated in "Definitions" section for "experimental/investigational."
5. If we determine that a service is experimental or investigational, and therefore not covered, you may appeal our decision. We will respond in writing within 20 working days after receipt of a claim or other fully documented request for benefits, or a fully documented appeal. The 20-day period may be extended only with your informed written consent.
6. Services or supplies not medically necessary for vision care.
7. Charges for broken appointments.
8. Services, supplies and procedures related to altering the refractive character of the cornea, and their direct results, including but not limited to, radial keratotomy, corneal modulation, keratomileusis or refractive keratoplasty.
9. Continuous blend lenses in excess of the benefit listed in the schedule.
10. An eye examination required by your employer as a condition of employment and which your employer is required to provide due to a labor agreement.
11. Any services or supplies for which no charge is made, or would not have been made if this plan were not in effect, or for charges for services or supplies for which you are not legally liable.
12. Services or supplies that you furnish to yourself or that are furnished to you by a provider who lives in your home or is related to you by blood, marriage or adoption. Examples of such providers are your spouse, parent, or child.
13. We do not provide this benefit for:
    - Charges in excess of stated benefit maximums
    - Medical and surgical diagnosis or treatment of illness or injury that affects vision, including fundus photography to diagnose a medical eye condition
    - Drugs or medicines, whether or not they require a prescription
    - Vision therapy, eye exercise or any sort of training to correct muscular imbalance of the eye
    - Extra glasses, frames or contact lenses
    - Replacements due to loss or theft except at normal benefit intervals stated under "Lenses" and "Frames"
    - Vision services and supplies:
      - not specifically listed as covered
      - covered under a WEA medical plan
      - fitted or ordered before an enrollee’s effective date of coverage under this plan, including eyeglass lenses, frames and contact lenses

- not furnished by a licensed ophthalmologist, optometrist or optician
- Nonprescription glasses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light sensitive lenses, even if prescribed
- Supplies used for the maintenance of contact lenses

### Limitations

1. Eyeglass lenses or frames received during the same calendar year in which the enrollee receives an allowance for medically necessary contact lenses.
2. Eyeglass lenses or frames received during the same 2 calendar year period in which the enrollee receives an allowance for contact lenses.
3. If contact lenses (such as extended wear or astigmatic) or quadrifocal eyeglass lenses are purchased, benefits will be provided only up to benefit listed in the benefit maximum. You will be responsible for any difference, even if the provider is participating.
4. We do not provide this benefit for services or supplies received after the enrollee's coverage terminates. However, we will provide benefits for covered eyeglasses (eyeglass lenses or frames) or covered contact lenses ordered before the enrollee's termination date if the enrollee received a covered routine vision examination, which includes a refraction, during the 30-day period immediately before the termination date, and the eyeglasses or contact lenses are delivered to the enrollee within 30 days after the date of termination.
5. Services and supplies for which the enrollee is entitled to receive benefits from any federal, state or governmental plan, excluding Medicare, except as otherwise required by law are not covered.
6. Services and supplies to the extent that benefits are payable under the terms of any contract or insurance offering:
   - Motor vehicle medical, motor vehicle no-fault, or personal injury protection (PIP) coverage; or,
   - Commercial premises or homeowner's medical premises coverage, or other similar type of contract or insurance.

# GENERAL PROVISIONS

## NOTICE OF INFORMATION USE AND DISCLOSURE

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

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

- Underwriting and determining your eligibility for benefits and paying claims
- Coordinating benefits with other health care plans
- Conducting care management, case management, or quality reviews, and
- Fulfilling other legal obligations that are specified under the group contract

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

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

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

With reasonable notice, you may view your medical records at your provider's office and receive a copy of your records by paying for copying. To make these requests, contact your provider's office.

## TRANSFER OF BENEFITS: ASSIGNMENT, GARNISHMENT AND ATTACHMENT

All benefits are personal and available only to enrollees. They will not be provided for anyone else.

The right to payment under Premera Blue Cross's contract with the WEA is not subject to attachment or garnishment, and Premera Blue Cross/VSP will not honor any assignment of it to anyone. In paying for services, VSP may, at its option, make the payment to the enrollee, the participating employer group, the provider, another

carrier, or other party legally entitled to such payment under federal or state medical child support laws, or jointly to any of these. Such remittance shall discharge Premera Blue Cross/VSP to the extent of the amount remitted so that it shall not be liable to anyone aggrieved by its choice of payee.

### RIGHT OF RECOVERY

VSP will have the right, upon demand, to recover overpayments or payments obtained through fraud, error, mistake, or payments made in excess of the maximum amount necessary to satisfy the intent of the Coordination of Benefits provision (refer to "Additional Information"), made to the enrollee, the provider, other insurers, any service plans, any other organization, or on behalf of an enrollee, or someone who is not eligible to receive benefits.

If reimbursement is not made, such overpayments or payments will be deducted from future claims.

### FRAUDULENT CLAIMS

If the enrollee claims benefits for which no care, service or supply is received, the claims will be denied.

### VENUE

All suits or legal proceedings brought against VSP by you or anyone claiming any right under this plan must be filed:

- Within three years of the date VSP denied in writing the rights claimed under this plan, or of the completion date of the independent review process, if applicable; and
- In the State of Washington or the state in which you reside or are employed.

All suits or legal proceedings brought by us will be filed within the appropriate statutory period of limitation. In all suits or legal proceedings brought by us venue may lie, at our option, in King County, State of Washington.

### NOTICE OF OTHER COVERAGE

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

- Any legal action or claim against another party for a condition or injury for which we paid benefits; and the name and address of that party's insurance carrier
- The name and address of any insurance carrier providing personal injury protection (PIP), underinsured motorist, uninsured motorist, or any other insurance under which you are or may be entitled to recover compensation
- The name of any other group insurance plan(s) under which you are covered

## ADDITIONAL INFORMATION

### COORDINATING BENEFITS WITH OTHER VISION PLANS (COB)

When you have more than one health plan, "coordination of benefits" makes sure that the combined payments of all your plans don't exceed your covered health costs. You or your provider should file your claims with your primary plan. If you have Medicare, Medicare may submit your claims to your secondary plan. Please see “COB’s Effect On Benefits” below in this section for details on primary and secondary plans.

If you do not know which is your primary plan, you or your provider should contact any of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan(s) to determine which is primary and will let you know within 30 calendar days.

**Caution:** All health plans have timely filing requirements. If you or your provider fails to submit your claim to your secondary plan within that plan’s claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary plan, you or your provider will need to submit your claim to the secondary plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers any changes in your coverage.

#### Definitions

For the purposes of COB:

- A **plan** is any of the following that provides benefits or services for medical or dental care. If separate contracts are used to provide coordinated coverage for group members, all the contracts are considered parts

of the same plan and there is no COB among them. However, if COB rules don't apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB doesn't apply is treated as a separate plan.

  - "Plan" means: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or HMOs, closed panel plans or other forms of group coverage; medical care provided by long-term care plans; and Medicare or any other federal governmental plan, as permitted by law.
  - "Plan" **doesn't mean**: Hospital or other fixed indemnity or fixed payment coverage; accident-only coverage; specified disease or accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; non-medical parts of long-term care plans; automobile coverage required by law to provide medical benefits; Medicare supplement policies; Medicaid or other federal governmental plans, unless permitted by law.

- **This plan** means your plan's vision benefits to which COB applies. A contract may apply one COB process to coordinating certain benefits only with similar benefits and may apply another COB process to coordinate other benefits. All the benefits of your Premera Blue Cross plan are subject to COB, but your plan coordinates dental benefits separately from medical benefits. Dental benefits are coordinated only with other plans' dental benefits, while medical and vision benefits are coordinated only with other plans' medical and vision benefits.
- **Primary plan** is a plan that provides benefits as if you had no other coverage.
- **Secondary plan** is a plan that is allowed to reduce its benefits in accordance with COB rules. See "Effect On Benefits" later in this section for rules on secondary plan benefits.
- **Allowable expense** is a vision expense, including deductibles, coinsurance and copays, that is covered at least in part by any of your plans. When a plan provides benefits in the form of services, the reasonable cash value of each service is an allowable expense and a paid benefit. An amount that isn't covered by any of your plans isn't an allowable expense.
- An example of an expense that is **not** allowable is any amount over the highest of the expense amounts allowed by either the primary or secondary plan. This is true regardless of what method the plans use to set allowable expenses. However, when Medicare or a Medicare Advantage plan is primary to your other coverage, the allowable expense set by Medicare or the Medicare Advantage plan must be treated as the highest allowable.
- **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the calendar year, excluding any temporary visitation.

**Primary And Secondary Rules**

Certain governmental plans, such as Medicaid and TRICARE, are always secondary by law. Except as required by law, Medicare supplement plans and other plans that don't coordinate benefits at all must pay as if they were primary.

A plan that doesn't have a COB provision that complies with Washington regulations is primary to a complying plan unless the rules of both plans make the complying plan primary. The exception is group coverage that supplements a package of benefits provided by the same group. Such coverage can be excess to the rest of that group's plan. An example is coverage paired with a closed panel plan to provide out-of-network benefits.

The first of the rules below to apply decides which plan is primary. If you have more than one secondary plan, the rules below also decide the order of the secondary plans to each other.

**Non-Dependent Or Dependent** The plan that doesn't cover you as a dependent is primary to a plan that does. However, if you have Medicare, and federal law makes Medicare secondary to your dependent coverage and primary to the plan that doesn't cover you as a dependent, then the order is reversed.

**Dependent Children** Unless a court decree states otherwise, the rules below apply:

- **Birthday rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated or not living together, whether or not they were ever married:
  - If a court decree makes one parent responsible for the child’s health care expenses or coverage, that plan is primary. This rule and the court decree rules below apply to calendar years starting after the plan

is given notice of the court decree.

- If a court decree assigns one parent primary financial responsibility for the child but doesn't mention responsibility for health care expenses, the plan of the parent with financial responsibility is primary.
- If a court decree makes both parents responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
- If a court decree requires joint custody without making one parent responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
- If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:
  - The plan covering the custodial parent, first
  - The plan covering the spouse of the custodial parent, second
  - The plan covering the non-custodial parent, third
  - The plan covering the spouse of the non-custodial parent, last
- If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.

**Retired Or Laid-Off Employee** The plan that covers you as an active employee (an employee who is neither laid off nor retired) is primary to a plan covering you as a retired or laid-off employee. The same is true if you are covered as both a dependent of an active employee and a dependent of a retired or laid-off employee.

**Continuation Coverage** If you have coverage under COBRA or other continuation law, that coverage is secondary to coverage that isn't through COBRA or other continuation law.

**Please Note:** The retiree/layoff and continuation rules don't apply when both plans don't have the rule or when the "non-dependent or dependent" rule can decide which of the plans is primary.

**Length Of Coverage** The plan that covered you longer is primary to the plan that didn't cover you as long.

If none of the rules above apply, the plans must share the allowable expenses equally.

**COB's Effect On Benefits**

The primary plan provides its benefits as if you had no other coverage.

A plan may take into account the benefits of another plan **only** when it is secondary to that plan. The secondary plan is allowed to reduce its benefits so that the total benefits provided by all plans during a calendar year are not more than the total allowable expenses incurred in that year. For each claim, the benefits of the primary and secondary plans must total 100% of the highest allowable expense allowed for the service or supply by either plan. **However, the secondary plan is never required to pay more than its benefit in the absence of COB plus any savings accrued from prior claims incurred in the same calendar year.**

The secondary plan must credit to its deductible any amounts it would have credited if it had been primary. It must also calculate savings for each claim by subtracting its secondary benefits from the amount it would have provided as primary. It must use these savings to pay any allowable expenses incurred during that calendar year, whether or not they are normally covered.

Certain facts about your other health care coverage are needed to apply the COB rules. We may get the facts we need for COB from, or give them to, other plans, organizations or persons. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the primary plan fails to pay within 60 calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim to the secondary plan to make payment as if the secondary plan was primary. In such situations, the secondary plan is required to pay claims within 30 calendar days of receiving your claim and notice that your primary plan has not paid. However, the secondary plan may recover from the primary plan any excess amount paid under the “Right of Recovery/Facility of Payment” provision in the plan.

**Right Of Recovery/Facility Of Payment** If your other plan makes payments that this plan should have made, we have the right, at our reasonable discretion, to remit to the other plan the amount we determine is needed to comply with COB. To the extent of such payments, we are fully discharged from liability under this plan. We also have the right to recover any payment over the maximum amount required under COB. We can recover excess

payment from anyone to whom or for whom the payment was made or from any other issuers or plans.

For questions about COB, please contact our WEA Select Service Team at 1-800-932-9221 or the Washington Insurance Department**.**

### Coordination of Benefits Between Two VSP Plans

When a husband and wife both have coverage with VSP as an eligible employee, coordination of benefits are available. The following outline explains that there are four options from which each family member may choose.

- **One Pair Of Glasses** When one pair of glasses is obtained, the benefits can be coordinated to pay for the copayment, plus most - if not all - cosmetic extras or designer frames;
- **Two Pair of Glasses** Two pairs of glasses may be received when the benefits are coordinated. The copayment will apply to the second pair of glasses. However, the first copayment - and some cosmetic extras - will be paid for if both pair of glasses are received at the same time. If glasses are received at different times, both copayments and all cosmetic extras will be between the participating vision provider and the patient;
- **Service And Materials From Nonparticipating Providers** VSP will reimburse the patient up to twice the schedule allowance, not to exceed the actual examination fee and the cost of the materials subject to Plan limitations;
- **Cosmetic Contact Lenses** An individual may choose to receive glasses and contact lenses. The normal copayment and limitations will apply to the glasses. However, the patient may also receive an allowance for contact lenses. If just cosmetic contact lenses are selected, twice the normal schedule of allowances will apply, not to exceed the actual charges.

Please tell your VSP participating provider if you choose to coordinate your benefits between two VSP plans.

There may be situations where you might not be eligible for benefits under your primary VSP coverage, but benefits may be available under your secondary VSP coverage. Please contact VSP to discuss this further if you have coverage under two VSP plans.

### Coordination of Benefits Between VSP and Another Carrier

The total of all contributing coverages may pay up to, but no more than, 100 percent of your fees for services and materials provided.

### Effect of Medicare

As a rule, Medicare does not cover routine vision care. However, Medicare may cover glasses or eye exams for certain medical conditions. If Medicare does cover a service or supply that this plan covers, federal law may require this plan to be primary to Medicare.

When this plan is not primary, we coordinate benefits with Medicare.

## RIGHTS TO BENEFITS AFTER TERMINATION

Benefits are not provided for services, treatment, medical attention or care which an enrollee received after his or her termination of coverage, except as specified in the "Limitations" section, item 3.

No rights are vested under this plan.

# YOUR IDEAS, QUESTIONS, COMPLAINTS, AND APPEALS

As an enrollee you have the right to offer your ideas, ask questions, and voice complaints and submit appeals. Our goal is to listen, resolve your problems, and improve our service to you. If English is not your primary language and you need help, please call the Vision Service Plan.

## WHEN YOU HAVE IDEAS

We would like to hear from you on ways we can continue to improve our service. If you have an idea, suggestion, or opinion, please let us know. You can call us at the numbers listed below or send your ideas and comments to:

Premera Blue Cross
Customer Assessment Manager
P. O. Box 327
Seattle, WA 98111-0327

## WHEN YOU HAVE QUESTIONS

Call your provider of care when you have questions about the health care services you receive. Please call the Vision Service Plan with any other questions regarding your vision plan.

Toll-Free: 1-800-877-7195;
Hearing impaired TDD: 1-800-428-4833

## WHEN YOU HAVE A COMPLAINT

A **complaint** is an expression of dissatisfaction about a benefit or coverage decision, customer service, or the quality or availability of a health service. The complaint process lets the Vision Service Plan to quickly and informally correct errors, clarify decisions or benefits, or take steps to improve our service. We recommend, but do not require, that you take advantage of this process when you are not content with a benefit or coverage decision. If the Vision Service Plan finds that you need to submit your complaint as a formal appeal, they will tell you.

When you have a complaint, call or write the Vision Service Plan. If your complaint is about the quality of care you receive, it will be given to our Clinical Quality Management staff for review. If the complaint is of a non-medical nature relating to a provider, it will be given to our Provider Network staff for review. We will let you know when we have received your written complaint. We may also request more information when needed. When we receive all needed information, we will review your complaint and notify you of the outcome and the reason for it as soon as possible, but in no case no more than 30 calendar days.

## WHEN YOU HAVE AN APPEAL

An appeal is an oral or written request that we reconsider 1) our decision on a complaint, or 2) our decision to deny, modify, reduce, or end payment, coverage, or authorization of coverage. We must receive your appeal within 180 calendar days of the date you received notice of our decision. If you are appealing a complaint decision, we must receive your appeal within 180 calendar days of the date we gave you that decision.

You have the right to give us comments, documents, or other information to support your appeal.

Although we will accept an appeal made by phone to our Vision Service Plan, it is preferable to put appeals in writing. Please send all written appeals to the address shown below. We will let you know when we receive your appeal.

You may mail appeals to:

Vision Service Plan
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670

## APPEALS PROCESS

Our standard appeal process has two levels of review:

**Level I:** The Level I Appeal panel will decide most appeals within 30 calendar days. This panel will include health care providers who were not involved in the initial decision. We can extend our review time up to 15 more calendar days if we need more information. You will be notified if a delay occurs.

There are three exceptions to the 30-day time limit:

- **A decision to change, reduce or end an ongoing service**

  We will mail you a response within 14 calendar days of the date we receive your appeal, unless we notify you that we need an extension. The extension will be no more than 30 calendar days from the day we receive your appeal, unless you agree to a longer one.

- **Denial of an experimental or investigational service**

  We will mail you a response within 20 calendar days from the date we receive your appeal. The 20-day period may be extended with your informed written consent.

- **Urgent appeals (See "Urgent Appeals" below)**

If you do not agree with the decision reached in the Level I review, you may ask us to perform a Level II review of your appeal. You may also send us more information to support your appeal. **You must make your request for a Level II review no more than 60 calendar days after the date you receive our Level I decision**. An extension to the 60-day limit may be granted in the event the enrollee needs to obtain additional medical documentation, physician consultations or opinions, if the enrollee is hospitalized or traveling, or for other reasonable cause beyond the enrollee's control. In no case will the extension exceed 180 days.

**Level II:** Your appeal will be reviewed by a Vision Service Plan panel that includes health care providers and is different from the Level I panel. You and/or your authorized representative may meet with the panel. Unless your appeal is deemed urgent (see "Urgent Appeals" below), the panel will evaluate all the information within 45 calendar days of the date we receive your Level II request.

If you are appealing a decision to deny, change, reduce or end payment coverage, or authorization of coverage, and you are not satisfied with the outcome of the Level II appeal, you may ask for an independent review (see "Independent Review" below). You may also ask for an independent review if we do not give you our Level I or Level II decision within the time limits stated. We must receive your request within 60 calendar days of the Level I decision.

**Independent Review:** are conducted by an independent review organization (IRO), which is an organization of medical experts qualified to review your appeal. We will use IROs that have been certified by the state Department of Health. We will submit your file to the IRO on your behalf and will pay the charges of the IRO. The IRO will give you its decision in writing. We will implement the IRO's determination promptly.

### Other Information About the Appeals Process

**Notice:** Unless your appeal is deemed urgent, we will mail you a written notice of our Level I and Level II decisions within 5 calendar days after the review is complete.

**Urgent Appeals:** We deem your appeal urgent when your physician or other provider advises us that a delay will harm your health. Level I and II responses on urgent appeals will be given within 24 hours after the appeal is received.

**Appeals Of Ongoing Care:** While you are appealing a decision to change, reduce or end coverage because the service or level of service is no longer medically necessary or appropriate, we will suspend our denial. Our coverage for services received during the appeal period does not and should not be construed to reverse our denial. **If our initial decision is upheld, you must repay us all amounts that we have paid for such services. You will also have to pay providers any difference between our allowable charge and the provider's billed charge.**

This appeals process may be amended as required by state and federal health reform laws and regulations. Please call the Vision Service Plan if you have questions or need more information about our complaint or appeal process. The number is shown in "When You Have Questions."

## WEA CLAIM APPEAL PROCESS

If you do not agree with a claim denial made by VSP, you may submit a further appeal to the Washington Education Association. The claim may be appealed by the enrollee to the WEA Board or its appointed Benefit Services Advisory Board. The Board, or Benefit Services Advisory Board, shall conduct a hearing at which the participant shall be entitled to present his or her opinion, and any evidence in support thereof. Thereafter, the Board or Benefit Services Advisory Board shall issue a written decision affirming, modifying or setting aside the former action. For more information on WEA claim review, you may contact Aon Consulting at (206) 467-4646.

The Board of Directors or its appointed Benefit Services Advisory Board of the Washington Education Association

has the authority under this contract to reconsider claims for benefits which have been denied in whole or in part by Premera Blue Cross and to determine if additional benefits should be provided. This provision will provide a means whereby a claim for benefits can be reconsidered and additional benefits provided to the extent herein specified and to the extent there are WEA funds available to cover such additional benefits. The circumstances under which the appointed Benefit Services Advisory Board may approve additional benefits when a claim for benefits is denied are outlined in the WEA "Procedure for Benefit Services Claim Review."

It is further understood that (i) costs incurred in connection with a claims appeal such as attorneys fees, travel expenses and so forth are not covered, (ii) that the Board of Directors or its appointed Benefit Services Advisory Board cannot have access to medical information without the written permission of the Subscriber, and (iii) the decisions made under this provision do not establish precedents.

# DEFINITIONS

These terms are used in this benefit booklet:

### Allowable Charge

The allowable charge shall mean one of the following:

- **Contracting Providers**

  For any given service or supply, the amount these providers have agreed to accept as payment in full pursuant to the applicable provider agreement. These providers agree to seek payment from the plan when they furnish covered services to you. You will be responsible only for any applicable deductibles, copays, coinsurance, charges in excess of the stated benefit maximums, and charges for services and supplies not covered under this plan.

  Your liability for any applicable deductibles, coinsurance, copays, and amounts applied toward benefit maximums will be calculated on the basis of the allowable charge.

- **Non-Contracting Providers**

  The allowable charge will be no greater than the maximum allowance we otherwise would have allowed had the medically necessary covered services been furnished by a provider that has a contracting agreement.

  When you seek services from providers that do not have a contracting agreement, your liability is for any amount above the allowable charge, and for any deductibles, coinsurance, copays, amounts in excess of stated benefit maximums, and charges for noncovered services.

We reserve the right to determine the amount allowed for any given service or supply.

### Bargaining Unit

Any defined group of employees covered by a negotiated labor agreement; or in the absence of a negotiated labor agreement, a bona fide employee classification.

### Calendar Year

A period of 12 consecutive months beginning on January 1 and ending on December 31 of a given year.

### Contact Lenses

Contact lenses prescribed to improve visual sharpness that an enrollee chooses to wear instead of eyeglasses for reasons of comfort or appearance.

### Effective Date

The date on which the enrollee's coverage starts under this plan. This date is established by, and appears on the records of, Premera Blue Cross/VSP. If an enrollee's coverage lapses and is reinstated, the enrollee's reinstatement date will be the effective date.

### Enrollee

The subscriber or any eligible dependent enrolled for coverage under this plan.

### Exclusion

A provision that states VSP has no obligation under this plan to provide any benefits.

## Experimental/Investigational

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

- A drug or device which cannot be lawfully marketed without the approval of the United States Food and Drug Administration, and has not been granted such approval on the date the service is provided.
- The service is subject to oversight by an institutional review board.
- Reliable evidence does not demonstrate the safety and efficacy of the service, nor does it define a specific role for the service in clinical evaluation, management, or treatment.
- The service is the subject of ongoing clinical trials or other continuing scientific research to determine its maximum tolerated dose, toxicity, safety, or efficacy.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.
- Evaluation of reliable evidence indicates that the service does not show a demonstrable benefit for a particular disease or condition.

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

  The documentation used to establish our criteria will be made available for your examination at our office, if you send us a written request.

## Injury

Physical harm or disability sustained by the enrollee which is the direct result of an accident, independent of disease or bodily infirmity or any other cause. The injury must have occurred at an identifiable time and place. Injuries do not include illness or infection, except infection of a cut or wound resulting from an accident.

## Limitation

The exclusion or reduction of a specific benefit.

## Medically Necessary Contact Lenses

Contact lenses prescribed for certain medical conditions of the eye that prevents an enrollee from achieving a specified level of visual acuity through the wearing of conventional eyeglasses. Examples of medical conditions of the eye include aphakia and keratoconus.

## Nonparticipating Vision Care Provider

A vision care provider (licensed ophthalmologist, optometrist or optician ) that, at the time services were rendered, does not have an agreement in effect with Premera Blue Cross to furnish vision services to enrollees.

**Please note:** When you receive services from a nonparticipating provider, you will be responsible for paying any difference between the allowable charge and the provider's billed charge.

## Participating Employer Group

A bargaining unit or other bona fide employee classification of an eligible employer or school district which has elected to offer this plan to all its eligible employees.

## Participating Vision Care Provider

A vision care provider (licensed ophthalmologist, optometrist or optician ) that, at the time services were rendered, has an agreement in effect with Premera Blue Cross to furnish vision services to enrollees.

## Subscriber

The employee who is eligible for the benefits of this vision care plan. The employee and dependents eligible for coverage are also referred to as "enrollees."

## Subscription Charges

The monthly rates established by us as consideration for the benefits offered in this plan.

**VSP**

Vision Service Plan, administrator of the benefits of this plan.

**WEA**

Washington Education Association

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# WASHINGTON EDUCATION ASSOCIATION
## WEA Select Vision Plans B, C, E & F
## Benefit Booklet Endorsement

**This benefit booklet endoresement clarifies the benefits and provisions in your Premera Blue Cross Vision Plan. The changes described below are effective on October 1, 2011.**

## INTRODUCTION

**The booklet Introduction has been modified to provide information on how you may request a review by the WEA Benefit Services Advisory Board (BSAB). The following text replaces it:**

### INTRODUCTION

Your WEA Select Vision Plan was designed specifically for school employees in Washington by the Washington Education Association (WEA) in cooperation with Aon Hewitt (Employee Benefits Consultant) Premera Blue Cross in collaboration with Vision Service Plan (VSP).

The WEA is the policyholder for this vision benefit plan. The WEA retains full and exclusive authority, at its discretion, to determine its availability. The plan is not guaranteed to continue indefinitely, and it may be altered or terminated at any time.

The WEA Benefits Services Advisory Board (BSAB) reviews all plan benefits and limitations, and they are approved by the WEA Board of Directors. Your suggestions for plan improvements are always welcome and may be forwarded to the WEA or Aon Hewitt.

**To understand how your benefits are paid, please review your benefit booklet when you enroll.** As you incur vision expenses, you may wish to review the section which applies to them.

Call Vision Service Plan (VSP) at the following numbers if you have questions on coverage or claims:

Toll-Free: 1-800-877-7195
Hearing-impaired TDD: 1-800-428-4833-5357

**Throughout the booklet, we use many terms that have specific meaning under this plan. The terms "you" and "your" refer to the enrollees under this plan. The terms "we," "us," and "our" refer to Premera Blue Cross.**

### WEA CLAIM REVIEW

The WEA Board of Directors or its appointed Benefit Services Advisory Board (BSAB) has the authority under this contract to reconsider claims for benefits which have been denied in whole or in part by Premera Blue Cross and to determine if additional benefits should be provided. This provision will provide a means whereby a claim for benefits can be reconsidered and additional benefits provided to the extent herein specified and to the extent there are WEA funds available to cover such additional benefits. The circumstances under which the appointed BSAB may approve additional benefits when a claim for benefits is denied are outlined in the WEA "Procedure for Benefit Services Claim Review."

If you do not agree with a claim denial made by Premera Blue Cross, you may submit a request for review. The BSAB shall conduct a hearing at which the participant shall be entitled to present his or her opinion, and any evidence in support thereof. Thereafter, BSAB shall issue a written decision affirming, modifying or setting aside the former action. For more information on the WEA claim review, you may contact Aon Hewitt at 206-467-4646.

Costs incurred by a claimant in preparing or presenting an appeal to the BSAB, such as attorney fees, copying or postage charges or travel expenses, must be borne by the claimant, and the claimant will be asked to sign a written consent to have the pertinent medical information provided to the BSAB.

## APPEALS PROCESS

**The WEA Select Vision Plans are administered to comply with the requirements of the Patient Protection and Affordable Care Act (PPACA), also known as federal health care reform. Federal and state authorities continue to issue new and revised guidance, including laws and regulations, regarding administration of health plans. If additional laws or regulations are issued, this plan will be administered in accordance with the applicable requirements.**

**The "What If I Have A Question Or Want To Appeal A Claim Decision?" section is deleted and replaced with the following:**

### YOUR IDEAS, QUESTIONS, COMPLAINTS AND APPEALS

As a Premera Blue Cross enrollee, you have the right to offer your ideas, ask questions, voice complaints and request a formal appeal to reconsider decisions we have made. Our goal is to listen to your concerns and improve our service to you.

### WHEN YOU HAVE IDEAS

We would like to hear from you. If you have an idea, suggestion, or opinion, please let us know. You can contact us at the addresses and telephone numbers found on the inside front cover of this benefit booklet.

If English is not your primary language and you need an interpreter to help, please call us to request an interpreter. We use a language translation service and can help guide you through this process.

### WHEN YOU HAVE QUESTIONS

Please call the WEA Select Customer Service Team with any questions you may have regarding your health benefit plan. We suggest that you call your provider of care when you have questions about the health care services they provide.

### COMPLAINTS PROCESS

You can call or write to us when you have a complaint about a benefit or coverage decision, customer service, or the quality or availability of a health care service. The complaint process allows the WEA Select Customer Service Team to quickly and informally correct errors, clarify benefits, or take steps to improve our service. We recommend, but don't require, that you take advantage of this process when you have a concern about a benefit or coverage decision. There may be times when the WEA Select Customer Service Team will ask you to submit your complaint for review through the formal appeals process outlined below.

We will review your complaint and notify you of the outcome and the reasons for our decision as soon as possible, but no later than 30 days from the date we received your complaint.

### WHEN YOU DISAGREE WITH A PAYMENT OR BENEFIT DECISION

If we declined to provide payment or benefits in whole or in part, and you disagree with that decision, you have the right to request that we review that adverse benefit determination through a formal, internal appeals process.

#### What is an adverse benefit determination?

An adverse benefit determination is a decision to deny, reduce, or terminate coverage, or not pay for a benefit, including a denial of part of a claim due to the terms of a plan or health insurance coverage, including copayments, deductibles, or other cost sharing requirements, based on:

- A determination of an individual's eligibility to participate in a plan or health insurance coverage, or rescission of coverage;
- A determination that a benefit is not a covered benefit;
- The imposition of a preexisting condition exclusion, source or injury exclusion, network exclusion, or other limitation on otherwise covered benefits; and
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

### APPEALS PROCESS

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

**Your Level I internal appeal** will be reviewed by individuals who were not involved in the initial adverse benefit

determination. They will review all of the information relevant to your appeal and will provide a written determination. If you are not satisfied with the decision, you may request a Level II appeal.

**Your Level II internal appeal** will be reviewed by a panel that includes a health care provider, if the adverse decision involved medical necessity, experimental, investigational or ongoing care, and other individuals who were not involved in the Level I appeal. You may participate in the Level II panel meeting in person or by phone to present evidence and testimony. Please contact us for additional information about this process.

Once the Level II review is complete, we will provide you with a written determination. If you are not satisfied with the final internal appeal decision, you may be eligible to request an External Review, as described below.

Please see "How do I file an internal appeal," below, for details about timeframes for requesting an appeal and where to submit one.

**Who may file an internal appeal?**

You or your authorized representative (someone you have named to act on your behalf) may file an appeal. To appoint an authorized representative, you must sign an authorization form and mail or fax it to the address or phone number listed below in the "How do I file an internal appeal" section. This release provides us with your authorization for this person to appeal on your behalf and allows our release of information, if any, to them.

Please call the WEA Select Customer Service Team for an Authorization For Release form, or you can obtain it at www.premera.com/wea on the "Forms" page.

**How do I file an internal appeal?**

You or your authorized representative may file an appeal by calling the WEA Select Customer Service Team or by writing to us at the address listed below. We must receive your appeal request as follows:

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

You may submit your written appeal request to:

VSP
PO Box 2350
Rancho Cordova, CA 95899

Or, you may fax your request to:

Appeals Department
(916) 858-5569

If you need help filing an appeal, or would like a copy of the appeals process, please call the WEA Select Customer Service Team at the number listed inside the front cover of this benefit booklet. You can also get a description of the appeals process by visiting the "Forms" page on www.premera.com/wea.

**How will I know that you received my request for an appeal?**

We will provide you a written notice acknowledging our receipt of your appeal request. This notice will also include a copy of the appeals process and the timeline used to review your appeal and when we will provide our written decision.

**What if my situation is clinically urgent?**

If your provider believes that your situation is urgent, your appeal will be conducted on an expedited basis. An urgent situation means one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. You may request an expedited internal appeal by calling the WEA Select Customer Service Team. If you are eligible for an external review, you may also request an expedited external review at the same time you request an expedited internal appeal.

**Can I provide additional information for my appeal?**

You may supply additional information to support your appeal at the time you file it or at a later date by mailing or faxing the information to the address and fax number listed above. Please provide us with this information

as soon possible.

**Can I request copies of information relevant to my appeal?**

In your appeal request, you can ask for copies of information relevant to the adverse benefit determination. We will provide this information as well as any new or additional information we considered, relied upon or generated in connection to your appeal as soon as possible and free of charge. You will have the opportunity to review this information and respond to us before we make our decision.

**What happens next?**

We will review the adverse benefit determination and provide you with a written decision. If we continue to deny the payment, coverage, or service requested, you will be provided information about your right to a Level II internal appeal or your right to an External Review at the end of the internal appeals process.

**Appeals Regarding Ongoing Care**

If you appeal a decision to change, reduce or end coverage of ongoing care for a previously approved course of treatment because the service or level of service is no longer medically necessary, we will suspend our denial of benefits during the internal appeal period. Our provision of benefits for services received during the internal appeal period does not, and should not be construed to, reverse our denial. If our decision is upheld, you must repay us all amounts that we paid for such services. You will also be responsible for any difference between our allowable charge and the provider's billed charge.

**WHEN AM I ELIGIBLE FOR EXTERNAL REVIEW?**

If you are not satisfied with the final internal adverse benefit determination regarding our decision to modify, reduce, or end payment, coverage or authorization of coverage, you may have the right to have our decision reviewed by an Independent Review Organization (IRO). An IRO is an independent organization of medical reviewers who are certified by the state of Washington Department of Health to review medical and other relevant information. There is no cost to you for an external review.

We will send you an External Review Request form at the end of the internal appeal process notifying you of your rights to an external review. We must receive your written request for an external review within four months of the date you received the final internal adverse benefit determination. Your request must include a signed waiver granting the IRO access to your medical records and other materials relevant to your request.

We will notify the IRO of your request for an external review. The IRO will let you, your authorized representative and/or your attending physician know where additional information may be submitted directly to the IRO and when the information must be provided. We will forward your medical records and other relevant materials for your external review to the IRO. We will also provide the IRO with any additional information they request that is reasonably available to us.

**What if my situation is urgent?**

If your provider believes that the situation is urgent, your external review will be conducted on an expedited basis. An urgent situation means one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for an external review decision. You can request an expedited external review by calling the WEA Select Customer Service Team.

**How will I know when the IRO has completed the external review?**

Once the external review is completed, the IRO will notify you and us in writing of their decision.

If you have requested an expedited external review, the IRO will notify you and us of their decision immediately by phone, e-mail or fax after they make their decision, and will follow up with a written decision by mail.

**What happens next?**

Premera is bound by the decision made by the IRO. If the IRO overturned the final internal adverse benefit determination, we will implement their decision.

If the IRO upheld the final internal adverse benefit determination, there is no further review available under this plan's internal appeals or external review process. However, you may have other remedies available under state or federal law, such a filing a lawsuit.

**OTHER RESOURCES TO HELP YOU**

If you have questions about understanding a denial of a claim or your appeal rights, you may contact the WEA Select Customer Service Team for assistance. You may also seek assistance from the Washington State Office of the Insurance Commissioner's Consumer Assistance Program at any time during this process:

Washington Consumer Assistance Program
Office of the Washington Insurance Commissioner
5000 Capitol Blvd.
Tumwater, WA 98501

Phone: 1-800-562-6900
Email: cap@oic.wa.gov
On line: www.insurance.wa.gov

## WHEN COVERAGE ENDS

**The "When Your Coverage Ends" section of your booklet has been revised to clarify that coverage for a dependent child does not end if the child gets married.**

### WHEN YOUR COVERAGE ENDS

Coverage for the subscriber and all dependents under this vision plan will stop at the end of the period for which the appropriate subscription charges were paid, or if one of the following occurs:

Subscriber and Dependents:

- The subscriber ceases to meet the eligibility requirements
- The subscriber is no longer employed by or connected with the participating employee group, or the participating employee group no longer participates in this plan
- The next monthly subscription charge is not paid when due or within the grace period
- The contract between the WEA and Premera Blue Cross is cancelled

Spouse:

- His or her marriage to the subscriber terminates due to divorce or annulment or, if earlier, when the subscriber is no longer legally responsible for covered expenses incurred by the spouse
- The subscriber dies or is no longer covered under this plan

Dependent Child(ren):

- Reaches the age of 26 (unless developmentally disabled or physically handicapped - See "Who Is Covered And When")
- The subscriber dies or is no longer covered under this plan

If the subscriber is no longer employed by or eligible for coverage with the participating employee group or a family member is no longer eligible, coverage will be cancelled automatically without notice at the end of the period for which subscription charges have been appropriately paid. **Refunds will not exceed more than 60 days worth of subscription charges, based on the date a change is reported to us**. See "Continuation Of Group Coverage - COBRA" for continued benefits.

**All other provisions of your plan remain unchanged. This endorsement becomes a part of your WEA Select Vision Plan benefit booklet, and should be kept with it for reference.**

**If you have questions regarding this information, please contact the WEA Select Customer Service Team at 1-800-932-9221.**

**Premera Blue Cross**

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# WASHINGTON EDUCATION ASSOCIATION
## WEA Select Vision Plans A, B, C, D, E, F
## Benefit Booklet Insert

**This benefit booklet insert clarifies the benefits and provisions in your Premera Blue Cross Vision Plan. The changes described in this Endorsement are effective on October 1, 2012.**

## DEPENDENT COVERAGE

**Eligibility verification is now required by the WEA Select Vision Plans. The following provision is added to the "Dependent Coverage" section as follows:**

### Verifying Dependents

The WEA verifies the eligibility of all dependents and reserves the right to request documents from enrollees that substantiate that the person(s) enrolled meet the criteria of the plan. Examples of documents that may be requested include, but are not limited to, government-issued marriage certificates, the Affidavit of Domestic Partnership, government-issued birth certificates and legal guardianship papers. If documents are not provided that verify your dependents' eligibility, their coverage will be canceled and COBRA will not be offered. The WEA Select Vision Plan will not reenroll dependents for whom you are unable to provide acceptable documentation.

## MARRIAGE

**We have revised the "Marriage" provision to clarify that coverage will begin on the first of the month following the date of marriage, except where another date is agreed upon by the district or bargaining unit and us. The provision is revised as follows:**

You must apply within 60 days of marriage to add a newly acquired spouse and children. Upon timely receipt of the completed enrollment application, coverage will begin on the first of the month following the date of marriage, except where another date is agreed upon by the district or bargaining unit and us.

## ELIGIBILITY – LEGAL SEPARATION

**We have revised the "Events That End Coverage" section of your benefit booklet to clarify that legal separation does not end coverage. The first bullet under "Spouse" has been revised as follows:**

### EVENTS THAT END COVERAGE

Coverage for the subscriber and all dependents under this vision plan will stop at the end of the period for which the appropriate subscription charges were paid, or if one of the following occurs:

Subscriber And Dependents:

- The subscriber ceases to meet the eligibility requirements
- The subscriber is no longer employed by or connected with the participating employee group, or the participating employee group no longer participates in this plan
- The next monthly subscription charge is not paid when due or within the grace period
- The contract between the WEA and Premera Blue Cross is cancelled

Spouse:

- The marriage to the subscriber terminates due to divorce or annulment.
- The subscriber dies or is no longer covered under this plan.

Dependent Child(ren):

- Reaches the age of 26 (unless developmentally disabled or physically handicapped - See "Who Is Covered And When")
- The subscriber dies or is no longer covered under this plan.

If the subscriber is no longer employed by or eligible for coverage with the participating employee group or a family member is no longer eligible, coverage will be cancelled automatically without notice at the end of the period for which subscription charges have been appropriately paid. **Refunds will not exceed more than 60 days worth of subscription charges, based on the date a change is reported to us**. See "Continuation Of Group Coverage - COBRA" for continued benefits.

**We have also removed all references of the term "legal separation" from your benefit booklet.**

## WHAT'S NOT COVERED?

**We have added a sentence to the limitation for federal, state and government programs, in the "What Your Vision Program Doesn't Cover" section, clarifying that this limitation applies even when a claim isn't filed for other coverage. The limitation in your benefit booklet has been revised as follows:**

Services and supplies for which the enrollee is entitled to receive benefits from any federal, state or governmental plan, excluding Medicare, except as otherwise required by law are not covered. This exclusion applies even if a claim was not filed.

**All other provisions of your plan remain unchanged. This insert becomes a part of your WEA Select Vision Plan benefit booklet, and should be kept with it for reference.**

**If you have questions regarding this information, please contact Customer Service. The phone number is located in your benefit booklet.**

**Premera Blue Cross**

PREMERA BLUE CROSS

# WASHINGTON EDUCATION ASSOCIATION
# WEA Select Vision Plans
# Benefit Booklet Endorsement

**The 2012-13 Contract between Washington Education Association and Premera Blue Cross is hereby amended effective January 1, 2013 as follows:**

## EMPLOYEE COVERAGE

**The following provision is added to the Employee Eligibility section, found in your benefit booklet under Employee Coverage.**

An employee may only be enrolled as a *subscriber* in a WEA Select Vision Plan through one school district.

## MARRIAGE

**The provision for enrolling a newly acquired spouse, found in your benefit booklet under Who Is Covered and When/Dependent Coverage is revised as follows:**

### Marriage

You may enroll a newly acquired spouse and children within 60 days of marriage. When enrollment is completed within 60 days of the marriage and payment of any required subscription charges has been received, coverage will begin on the first day of the month following the date of the event. If you do not enroll your spouse/children within the specified time period, they may not be enrolled until the next open enrollment period, unless there is a qualifying event.

## LOSS OF OTHER COVERAGE

**We have added the following provision for Loss of Other Coverage under the Who Is Covered And When/Loss Of Other Coverage section:**

## LOSS OF OTHER COVERAGE

Your dependents may enroll on this plan outside the open enrollment period if they had other health care coverage at the time this plan was offered, but later lost it. The loss of the other coverage *must* be due to one of the following events:

- Loss of eligibility for coverage for reasons including, but not limited to divorce, death, end of employment, retirement, a reduction in the number of hours employed, or reaching a non-WEA Select health care plan's annual benefit maximum.
- The employer terminates its contribution toward the coverage, or
- They were covered under COBRA and that COBRA coverage on a non-WEA Select Plan has been exhausted

A covered employee with an eligible dependent who qualifies as stated above may also enroll all eligible dependents.

If your dependents lose coverage for any other reason, you will have to wait until the next open enrollment period to enroll them.

When enrollment is completed within 60 days of the date the prior coverage ended, and payment of any required subscription charges has been received, coverage on the plan will begin on the first of the month after the loss of other coverage.

Please also see "Plan Transfers" and "Special Enrollments."

## SPECIAL ENROLLMENT

**We have added the following provision for Special Enrollment under the Who Is Covered And When section:**

### Special Enrollment

Your dependents may enroll on this plan outside the open enrollment period when you are enrolling a new dependent acquired through marriage, birth, adoption, assumption of legal guardianship, non-parental custody or due to a medical child support order as described earlier in this section.

For information on application procedures and coverage effective dates, please see the appropriate benefit booklet section (Marriage, Natural Newborn Children, Adoptive Children, Legal Guardianship/Non-Parental Custody or Medical Child Support Orders.)

## ENROLLMENT TERMINOLOGY

**Throughout the benefit booklet, all references to submission or receipt of the enrollment application are changed to "completion of enrollment."**

## COBRA

**All references to the subscriber and spouse being legally separated within the COBRA section of your benefit booklet have been removed.**

**All other provisions of your plan remain unchanged. This endorsement becomes a part of your WEA Select Vision Plan benefit booklet, and should be kept with it for reference.**

**If you have questions regarding this information, please contact Customer Service at 1-800-932-9221.**

**Premera Blue Cross**