HM Life Insurance Company

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222

HM Life Insurance Company certifies that you will be insured under the Policy Number issued to the Policyholder named below during the time, in the manner, and for the amounts provided in the Policy.

Chief Executive Officer

POLICYHOLDER:	WA State Health Care Authority SEBB
POLICY EFFECTIVE DATE:	January 01, 2021
CERTIFICATE EFFECTIVE DATE:	January 01, 2021
STATE OF ISSUE:	Washington

Your coverage under the Policy **HM Life Insurance Company** issued to the Policyholder is shown in this Certificate. If your coverage is changed by an amendment to the Policy, we will provide the Policyholder with a revised Certificate or other notice to be given to you.

PLEASE READ THIS CERTIFICATE CAREFULLY

This Certificate of Insurance has a Table of Contents to help you find specific provisions. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Certificate Effective Date shown above, at the Policyholder's address. The laws of the State of Issue shown above govern this Certificate.

“You" and "your" refer to the Employee; “we", "us", and "our" refer to **HM Life Insurance Company**. Other defined terms are printed with an initial capital letter.

GROUP VISION POLICY • NON-PARTICIPATING

Your Provider Network is DavisVision

THE POLICY PROVIDES LIMITED BENEFITS

Questions or Comments

We want to hear from you. If you have any questions about this Certificate, its benefits, the filing of claims, a complaint or a compliment, write to us at the address on the front of this Certificate. We thank you for your loyal patronage.

ADMINISTERED BY

Davis Vision, Inc., 175 E. Houston St., San Antonio, Texas 78205
For Customer Service Call: 800-328-4728

Table of Contents

INTRODUCTION

This Certificate is intended to be read in its entirety. In order to understand how benefits are calculated and all the conditions, exclusions and limitations applicable to its benefits, please read all the Certificate provisions carefully. We have issued to the Policyholder, for delivery to you, a Certificate setting forth the benefits of coverage under the Policy and Certificate.

Subject to the terms and conditions of the Policy, we agree to provide the benefits described in this Certificate in consideration of the Policyholder's remittance of the premium when due, or if you are being billed directly your payment of the required premium when due.

WAITING PERIOD

The Waiting Period is the period of time that must elapse from the date you are hired before you or your Dependents are eligible for a benefit payment under the Policy. This period is determined by the Policyholder's personnel practices. We will not pay for benefits received during the Waiting Period. If your coverage ends you may have to satisfy a new Waiting Period in order to become insured again under the Policy. See Reinstatement for exceptions.

COVERED PERSONS

Member
Dependents

SCHEDULE OF BENEFITS

Subject to the terms of the Policy, benefits are payable per Covered Person as shown in the Schedule of Benefits.

A Covered Person may use the Provider of their choice. There are two types of Providers - those that are part of the Network (In-Network Providers) and those that are not part of the Network (Out-of-Network Providers). The payment of benefits varies depending on the type of Provider chosen.

When services or Materials are received from a Provider who is part of the Network, you are responsible for the Copayment, if a cash payment is due the Provider.

Benefits for services or Materials received from a Provider outside of the Network are shown in terms of the dollar amount we will pay you for that service or Material. If you use an Out-of-Network Provider your total responsibility is the difference between the Reimbursement and the Provider's Actual Charge - we will pay the dollar amount of the Reimbursement for that service or Material or the Provider's Actual Charge if less. An Out-of-Network Provider may bill you for the difference.

You will not be paid a separate benefit, charged an additional Copayment or incur any additional cost for any item listed as "Included" or "Included – no Copayment".

ADULT SUBSCRIBERS 19 AND OVER	IN-NETWORK BENEFITS
Frequency – Renews:	
Eye Examination inclusive of Dilation (when professionally indicated)	Every calendar year on January 1
Spectacle Lenses	January 1 of even years
Frame	January 1 of even years
Contact Lens Evaluation, Fitting & Follow-Up Care	January 1 of even years
Contact Lenses (in lieu of eyeglasses)	January 1 of even years

Copayments	
Eye Examination	Included
Spectacle Lenses	Included
Contact Lens Evaluation, Fitting & Follow-Up Care	Included
Eyeglass Benefit – Frame	
Non-Collection Frame Allowance (Retail - you will be paid the retail Allowance shown for the frame or the Provider's charge, whichever is less):	$150
Visionworks Enhanced Frame	Included
Davis Vision Frame Collection (in lieu of the Non-Collection Frame Allowance):	
Fashion level	Included
Designer level	Included
Premier level	Included
Eyeglass Benefit - Spectacle Lenses	
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	Included
Tinting of Plastic Lenses	Included
Scratch-Resistant Coating	Included
Polycarbonate Lenses Children	Included
Polycarbonate Lenses Adults	$30 Co-payment
Ultraviolet Coating	$12 Co-payment
Anti-Reflective (AR) Coating Standard	$35 Co-payment
Anti-Reflective (AR) Coating Premium	$48 Co-payment
Anti-Reflective (AR) Coating Ultra	$60 Co-payment
Anti-Reflective (AR) Coating Ultimate	$85 Co-payment
Progressive Lenses Standard	$50 Co-payment
Progressive Lenses Premium	$90 Co-payment
Progressive Lenses Ultra	$140 Co-payment
Progressive Lenses Ultimate	$175 Co-payment
High-Index Lenses	$55 Co-payment
Polarized Lenses	$75 Co-payment
Plastic Photosensitive Lenses	$65 Co-payment
Scratch Protection Plan: Single Vision	$20 Co-payment
Scratch Protection Plan: Multifocal Lenses	$40 Co-payment
Contact Lens Benefit (in lieu of eyeglasses)	
Non-Collection Contact Lenses: Materials Allowance (you will be paid the Allowance shown for the Contact Lenses or the Provider's charge, whichever is less)	$150
Collection Contact Lenses (in lieu of Allowance for Non-Collection Contact Lenses): Materials - Disposable - Planned Replacement	 8 boxes/multi-packs 4 boxes/multi-packs
- Evaluation, Fitting & Follow-up Care	Included
Visually Required Contact Lenses (with prior approval) - Materials, Evaluation, Fitting & Follow-Up Care	Included
OUT-OF-NETWORK-BENEFITS	
Frequency – Renews:	
Eye Examination inclusive of Dilation (when professionally indicated)	January 1 of even years
Spectacle Lenses	January 1 of even years
Frame	January 1 of even years
Contact Lenses (in lieu of eyeglasses)	January 1 of even years

REIMBURSEMENT SCHEDULE (YOU WILL BE REIMBURSED AT THE FOLLOWING LEVELS OR PAID THE PROVIDER'S CHARGE, WHICHEVER IS LESS):	
Eye Examination:	$40
Single Vision Lenses:	$40
Bifocal Lenses:	$60
Trifocal Lenses:	$80
Lenticular Lenses:	$100
Contact Lenses:	$105
Visually Required Contact Lenses:	$225
Frame:	$50

MEMBERS UNDER THE AGE OF 19 IN-NETWORK BENEFITS	
Frequency – Renews:	
Eye Examination inclusive of Dilation (when professionally indicated)	Every calendar year on January 1
Spectacle Lenses	Every calendar year on January 1
Frame	Every calendar year on January 1
Contact Lens Evaluation, Fitting & Follow-Up Care	Every calendar year on January 1
Contact Lenses (in lieu of eyeglasses)	Every calendar year on January 1
Copayments	
Eye Examination	Included
Spectacle Lenses	Included
Contact Lens Evaluation, Fitting & Follow-Up Care	Included
Eyeglass Benefit – Frame	
Non-Collection Frame Allowance (Retail - you will be paid the retail Allowance shown for the frame or the Provider's charge, whichever is less):	$150
Visionworks Enhanced Frame	Included
Davis Vision Frame Collection (in lieu of the Non-Collection Frame Allowance):	
Fashion level	Included
Designer level	Included
Premier level	Included
Eyeglass Benefit - Spectacle Lenses	
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	Included
Tinting of Plastic Lenses	Included
Scratch-Resistant Coating	Included
Polycarbonate Lenses Children	Included
Polycarbonate Lenses Adults	Not Available
Ultraviolet Coating	Included
Anti-Reflective (AR) Coating Standard	$35 Co-payment
Anti-Reflective (AR) Coating Premium	$48 Co-payment
Anti-Reflective (AR) Coating Ultra	$60 Co-payment
Anti-Reflective (AR) Coating Ultimate	$85 Co-payment
Progressive Lenses Standard	$50 Co-payment
Progressive Lenses Premium	$90 Co-payment
Progressive Lenses Ultra	$140 Co-payment
Progressive Lenses Ultimate	$175 Co-payment
High-Index Lenses	Included
Polarized Lenses	$75 Co-payment
Plastic Photosensitive Lenses	Included
Scratch Protection Plan: Single Vision	$20 Co-payment

Scratch Protection Plan: Multifocal Lenses	$40 Co-payment
Contact Lens Benefit (in lieu of eyeglasses)	
Non-Collection Contact Lenses: Materials Allowance (you will be paid the Allowance shown for the Contact Lenses or the Provider's charge, whichever is less)	$300
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types	Included
Evaluation, Fitting & Follow-Up Care – Specialty Lens Types (you will be paid the Allowance shown or the evaluation, fitting and follow-up care or the Provider's charge, whichever is less)	$60 allowance
Collection Contact Lenses (in lieu of Allowance for Non-Collection Contact Lenses): Materials - Disposable - Planned Replacement	 8 boxes/multi-packs 4 boxes/multi-packs
- Evaluation, Fitting & Follow-Up Care	Included
Visually Required Contact Lenses (with prior approval) - Materials, Evaluation, Fitting & Follow-Up Care	Included

OUT-OF-NETWORK-BENEFITS	
Frequency – Renews:	
Eye Examination inclusive of Dilation (when professionally indicated)	Every calendar year on January 1
Spectacle Lenses	Every calendar year on January 1
Frame	Every calendar year on January 1
Contact Lenses (in lieu of eyeglasses)	Every calendar year on January 1
REIMBURSEMENT SCHEDULE (YOU WILL BE REIMBURSED AT THE FOLLOWING LEVELS OR PAID THE PROVIDER'S CHARGE, WHICHEVER IS LESS):	
Eye Examination:	$40
Single Vision Lenses:	$40
Bifocal Lenses:	$60
Trifocal Lenses:	$80
Lenticular Lenses:	$100
Contact Lenses:	$105
Visually Required Contact Lenses:	$225
Frame:	$50

Davis Vision Collection

In lieu of the frame Allowance, Covered Persons may choose to select any frame from the Davis Vision's Collection. The Collection is available at most participating independent provider offices and features three levels of frames.

In lieu of the non-Collection contact lens Allowance, Members may be fitted with contact lenses from the Davis Vision Collection. Contact lenses from the Davis Vision Collection include the evaluation, fitting and follow-up care.

Examination

An Exam or Eye examination includes (but is not limited to):

- Case history – chief complaint, eye and vision history, medical history
- Entrance distance acuities
- External ocular evaluation including slit lamp examination
- Internal ocular examination
- Tonometry
- Distance refraction – objective and subjective

- Binocular coordination and ocular motility evaluation
- Evaluation of pupillary function
- Biomicroscopy
- Gross visual fields
- Assessment and plan
- Advising on matters pertaining to vision care
- Form completion – school, motor vehicle, etc.
- Dilated Fundus Examination (DFE) (diagnostic procedure used in the detection and management of diabetes, glaucoma, hypertension and other ocular and/or systemic diseases) when professionally indicated.

Visually Required Contact Lenses

Visually Required contact lenses will only be covered when the treating Provider has determined that a Covered Person has a "chronic visual disturbance." For the purposes of this section, chronic visual disturbance means a physiologic change in a Covered Person's vision either innate or acquired that inhibits the Covered Person's ability to achieve functional vision with spectacles such that a Visually Required contact lens is required to achieve the minimum functional vision needed to carry out normal daily activities. Chronic visual disturbance may include the following conditions: Keratoconus, Myopia, progressive or malignant, Hyperopia, Anisometropia, Aniseikonia, Aphakia, Aniridia or Irregular Astigmatism.

Visually Required contact lenses are available only if the treating Provider sends a completed request and supporting documentation showing a diagnosis of one of the foregoing conditions to Davis Vision before the lenses are initially ordered. The Visually Required contact lenses are subject to the maximum benefit Allowance per Frequency period. The Covered Person's benefit is paid in full up to the maximum Allowance during each Frequency period. Any amount due over the Allowance for such lenses during the Frequency period is the Covered Person's responsibility.

Visually Required contact lenses are subject to prior approval. If advance approval for the initial Visually Required contact lenses is not obtained, the standard contact lens benefit may be applied if available. This limitation will not apply if it is shown that it was not reasonably possible to submit the request for approval.

Contact lens evaluation, fitting and follow-up care applies to standard daily wear, disposable, planned replacement, specialty and the Visually Necessary contact lens benefit.

Mail Order Replacement Contact Lens Program

A mail order contact lens replacement service for members is powered by ABB Optical Group. By accessing www.davisvisioncontacts.com, Members can easily order replacement contact lenses and have them shipped directly to their doorstep.

Eyeglass Warranty

Davis Vision provides a breakage warranty to repair or replace any Collection frame and/or lens(es) for a period of one year from the date of delivery. This warranty applies to eyeglasses (spectacle lenses, frames from the Davis Vision frame Collection and frames obtained from a national retail chain that is part of Davis Vision's Provider Network where the Davis Vision frame Collection is not displayed).

At Wal-Mart, Sam's Club and Costco locations a Covered Person will receive the full Allowance toward the location's everyday low pricing.

DEFINITIONS

Please note that certain words used in this Certificate have specific meanings. Other than references to they, them, their, you, your, yours, we, us or our, the words defined below and capitalized within the text of this Certificate have the meanings set forth below.

Allowable Charge means the amount negotiated between an In-Network Provider and us or our authorized representative as full payment for a Covered Expense shown in the Schedule of Benefits received or purchased by a Covered Person.

Allowance means a flat dollar amount payable under the Policy towards a Covered Expense from an In-Network Provider. Allowances are shown in the Schedule of Benefits. If the Providers charge is less than the Allowance we will only pay up to the Providers charge.

Average Retail Price means the charge made by other Providers rendering or furnishing vision care, treatment or supplies within the same geographic area.

We will base our determination of the retail price within a geographical area on a study or survey done to determine such charges. Consideration will be given to the nature and severity of the condition being treated including any complications which require additional time, skill, treatment or expertise.

Certificate means the document issued for delivery to the Covered Person that lists the benefits, conditions and limits of the Policy.

Collection means Davis Vision's frame or contact lens Collection shown in the Schedule of Benefits.

Copayment means the amount a Covered Person is required to pay to the Provider prior to an eye examination or toward the cost of Materials. Copayments are shown in the Schedule of Benefits.

Covered Expense means the benefits listed in the Schedule of Benefits. The term "Covered Expense" or "Covered Expenses" does not include:

1. Any services or Materials that are not listed in the Schedule of Benefits; or

2. Any services or Materials shown as "Not Covered" in the Schedule of Benefits; or

3. An additional exam, frame, pair of spectacle lenses or contact lenses for which you have already received either an "In-Network Benefit" or an "Out-of-Network Benefit" during any one Frequency period; or

4. More than one type of contact lens at a time during any one Frequency period; or

5. The fitting and follow-up care or adjustments to eyeglasses (frames and spectacle lenses - including Additional In-Network Items) or contact lenses (including evaluation, fitting and follow-up care) if vision correction is not recommended by a Provider following an eye examination.

Covered Person or Covered Persons means a person covered by this Policy. The types of Covered Persons insured under the Policy are shown under Covered Persons in the Schedule of Benefits. For example, if "Member" is shown we insure all eligible Members, if "Partner" is shown we insure the Employee's eligible Partner, and if "Children" is shown we insure all eligible Children.

Frequency means the time period shown in the Schedule of Benefits during which you are eligible for the Covered Expenses shown in the Schedule of Benefits. This time period is measured from the date of your last eye examination or the date you received the eyeglasses, frame or spectacle lenses or contact lenses.

In-Network Provider means a Provider who has entered into a contract with us or our authorized representative to provide eye examinations and/or Materials on an Allowable Charge basis. These Providers are part of our or our authorized representatives Network and will not bill you for more than:

1. The Copayment; or

2. Any difference between the Allowance and the amount he agreed to as total Reimbursement (the Allowable Charge).

Insurance means the group vision care insurance provided to you and your Dependents, if any, under the Policy.

Materials means frames and lenses provided to a Covered Person for ophthalmic correction under the terms and conditions of the Policy.

Member means a person:

1. Who is employed by the Policyholder as either an associate or employee; and

2. Who works the minimum number of hours to be eligible for the benefits provided by the Policy as determined by the Policyholder.

Network means a group of Providers who have entered into a contract with us or our authorized representative to provide eye examinations and/or Materials on a Scheduled Fee basis. Available Networks are shown in the Schedule of Benefits.

Out-of-Network Provider means Providers of optometric services who have not entered into a contract with us or our authorized representative to provide vision care services. An Out-of-Network Provider may bill you for the difference between the Reimbursement and his total charge (the Provider's Actual Charge).

Premium surcharge means a payment required from a subscriber, in addition to the subscriber's medical premium contribution, due to an enrollee's tobacco use or an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in their employer based group medical when:
• The spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the public employees benefits board (PEBB) Uniform Medical Plan (UMP) Classic; and
• The benefits have an actuarial value of at least ninety-five percent of the actuarial value of PEBB UMP Classic benefits.

Policyholder means the entity shown on the cover page of this Certificate.

Provider means a practitioner who is a legally qualified professional providing eye examinations, refractive and/or post-refractive services and surgery within the scope of their license. This term includes an ophthalmologist, an optometrist, an optician or a surgeon recognized as such in accordance with the laws of the State in which the services are provided. The Policy recognizes two categories of Providers; In-Network Providers and Out-of-Network Providers. Refer to these Definitions for further information.

This term does not include:

1. A person employed or retained by the Policyholder;

or

2. A parent, sibling, spouse, domestic partner or Child of the Covered Person.

Provider's Actual Charge means the total amount charged by a Provider for a Covered Expense.

Reimbursement means a flat dollar amount payable under the Policy towards a Covered Expense from an Out-of-Network Provider. Reimbursement levels are shown in the Schedule of Benefits. If the Providers charge is less than the Reimbursement we will only pay up to the Providers charge.

They, them, or their means an individual, male or female.

Visually Required means a service, supply or treatment which is:

1. Ordered by a Provider;

2. Required for treatment or management of a medical condition or symptom;

3. Provided in accordance with approved and generally accepted medical and surgical practice.

Vision Plan Eligibility and Enrollment

In these sections, “health plan” is used to refer to a plan offering medical, vision, or dental coverage, or a combination developed by the School Employees Benefits Board (SEBB) and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

Eligibility

The school employee’s SEBB Organization will inform the school employee whether or not they are eligible for benefits upon employment and whenever their eligibility status changes. The communication will include information about the school employee’s right to appeal eligibility and enrollment decisions. Information about a school employee’s right to an appeal can be found on page 15 of this certificate of coverage. For information on how to enroll see the “Enrollment” section.
To enroll an eligible dependent the subscriber must follow the procedural requirements described in the “Enrollment” section. The SEBB Program or SEBB Organization verifies the eligibility of all dependents and requires the subscriber to provide documents that prove a dependent’s eligibility.
The following are eligible as dependents:

1. Legal spouse.
2. State-registered domestic partner as defined in the state statute and substantially equivalent legal unions from other jurisdictions as defined in the Washington state statute.
3. Children. Children are eligible through the last day of the month in which their 26th birthday occurs except as described in subsection (g) of this section. Children are defined as the subscriber’s:
a. Children as defined in state statutes that establish a parent-child relationship, except when parental rights have been terminated;
b. Children of the subscriber’s spouse, based on the spouse’s establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild’s relationship to a subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;
c. Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
d. Children of the subscriber’s state-registered domestic partner, based on the state-registered domestic partner’s establishment of a parent-child relationship, except when parental rights have been terminated. The child’s relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber’s legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death;
e. Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;
f. Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber’s spouse, or subscriber’s state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child’s official residence with the custodian or guardian. Extended dependent child does not include a foster child unless the subscriber, the subscriber’s spouse, or the subscriber’s state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and
g. Children of any age with a developmental or physical disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age of 26. The following requirements apply to dependents with a disability:

• The subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26;

• The subscriber must agree to notify the SEBB Program in writing when the child is no longer eligible under this subsection;
• A child with a developmental or physical disability who becomes self-supporting is not eligible under this subsection as of the last day of the month in which they become capable of self-support;
• A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility under this subsection if they later become incapable of self-support; and
• The SEBB Program (with input from the medical plan if enrolled in medical) will periodically verify the eligibility of a dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. Verification will require renewed proof of disability and dependence from the subscriber.

Enrollment

A subscriber or their dependent is eligible to enroll in only one SEBB vision plan even if eligibility criteria is met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two parents working for the same or different SEBB Organizations may be enrolled as a dependent both parents but is limited to a single enrollment in SEBB vision .

A school employee is <u>required</u> to enroll in a vision plan under their SEBB Organization. A school employee must submit their enrollment online in SEBB My Account or return a *School Employee Enrollment/Change* form to their SEBB Organization when they become newly eligible for SEBB benefits. The enrollment must be received no later than 31 days after the date the school employee becomes eligible. If the school employee does not enroll online in SEBB My Account or return the School Employee Enrollment/Change form by the deadline, the school employee will be enrolled in Metropolitan Life Vision Plan and any eligible dependents cannot be enrolled until the SEBB Program's next annual open enrollment or when an event occurs that creates a special open enrollment.

How to enroll

A school employee must submit their enrollment in SEBB My Account or return a *School Employee Enrollment/Change* form to their SEBB Organization when they become newly eligible for SEBB benefits.

To enroll an eligible dependent, the school employee must include the dependent's information on the form and provide the required document(s) as proof of the dependent's eligibility. A dependent must be enrolled in the same health plan coverage as the subscriber. The dependent will not be enrolled in SEBB health plan coverage if the SEBB Program or the SEBB Organization is unable to verify their eligibility within the SEBB Program enrollment timelines.

A subscriber or their dependents may also enroll during the SEBB Program's annual open enrollment (see "Annual open enrollment" on page 11) or during a special open enrollment (see "Special open enrollment" beginning on page 11). The subscriber must provide proof of the event that created the special open enrollment.

A school employee must notify their SEBB Organization to remove dependents within 60 days from the last day of the month when the dependent no longer meets the eligibility criteria described under "Eligible Dependents" on page 8**. All other subscribers** must notify the SEBB Program **to remove a dependent** within 60 days from the last day of the month when the dependent no longer meets the eligibility criteria described under "Eligible dependents" on page 8. Consequences for not submitting notice within 60 days may include, but are not limited to:

• The dependent losing eligibility to continue SEBB vision coverage under one of the continuation coverage options described on page 14 of this certificate of coverage.
• The subscriber being billed for claims paid by the vision plan that were received after the dependent lost eligibility;

• The subscriber being unable to recover subscriber-paid insurance premiums for a dependent that lost their eligibility; and
• The subscriber being responsible for premiums paid by the state for the dependent's vision plan coverage after the dependent lost eligibility.

When vision coverage begins

For a school employee and their eligible dependents **enrolling when the school employee is newly eligible**, SEBB vision coverage begins the first day of the month following the date the school employee becomes eligible.

Exceptions:

1. The school employee's benefits will begin on the first day of work when their first day of work is on or after September 1, but not later than the first day of school for the current school year as established by the SEBB Organization.
2. When a school employee establishes eligibility toward SEBB benefits at any time in the month of August, the SEBB benefits begin on September 1 only if the school employee is also determined to be eligible for the school year that begins on September 1.

For a subscriber or their eligible dependents **enrolling during a special open enrollment**, vision coverage begins the first day of the month following the later of the event date or the date the online enrollment or required form is received.

Exceptions:

1. If the special enrollment is due to birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, SEBB vision coverage begins as follows:.
    - For an employee, vision coverage will begin the first day of the month in which the event occurs;
    - For the newly born child, vision coverage begins the date of birth;
    - For a newly adopted child, vision coverage begins on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier; or
    - For a spouse or state-registered domestic partner of a subscriber, vision coverage will begin the first day of the month in which the event occurs.

2. For a spouse or state-registered domestic partner of a subscriber, vision coverage begins the first day of the month in which the event occurs.
3. Enrollment of an extended dependent or a dependent with a disability will begin the first day of the month following the later of the event date or eligibility certification.

Annual Open Enrollment

School employees may make the following changes to their enrollment during the SEBB Program's annual open enrollment:
• Enroll or remove eligible dependents
• Change their vision plan

Other Subscribers may make the following changes to their enrollment during the SEBB Program's annual open enrollment:
• Enroll in or terminate enrollment in a vision plan
• Enroll or remove eligible dependents
• Change their vision plan

The school employee must submit the change online in SEBB My Account or return the required enrollment/change form to their SEBB Organization. All other subscribers must submit the form to the

SEBB Program. The form must be received no later than the last day of the annual open enrollment. The enrollment change will become effective January 1st of the following year.

Special open enrollment

A subscriber may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both. A special open enrollment event must be an event other than a school employee gaining initial eligibility or regaining eligibility for SEBB benefits. The special open enrollment may allow a subscriber to:

- Change their vision plan
- Enroll or remove eligible dependents

To make an enrollment change, the school employee must make the change online in SEBB My Account or submit the required form(s) to their SEBB Organization. All other subscribers must submit the form(s) to the SEBB Program. Subscribers self-paying for continuation coverage must submit their form(s) to the SEBB Program. The form(s) must be received no later than 60 days after the event that created the special open enrollment. In addition to the required forms, the SEBB Program or SEBB Organization will require the subscriber to provide proof of the dependent's eligibility, evidence of the event that created the special open enrollment, or both.

Exception: If a school employee wants to enroll a newborn or child whom the school employee has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption in SEBB health plan coverage, the school employee should notify their SEBB Organization by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required enrollment/change form must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. School employees should contact their payroll, or benefits office for the required forms.
See "Adding a New Dependent to Your Coverage" on page 13.

When can a subscriber change their health plan?

Any one of the following events may create a special open enrollment:

1. Subscriber gains a new dependent due to: a. Marriage or registering a state-registered domestic partnership;
b. Birth, adoption or when the subscriber assumes a legal obligation for total or partial support in anticipation of adoption; or
c. A child becomes eligible as an extended dependent through legal custody or legal guardianship.
2. Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;
4. Subscriber has a change in employment from a SEBB Organization to a public school district that straddles county lines or is in a county that borders Idaho or Oregon, which results in the subscriber having different medical plans available. The subscriber may change their election if the change in employment causes: a. The subscriber's current medical plan to no longer be available, in this case the subscriber may select from any available medical plan; or
b. The subscriber has one or more new medical plans available, in this case the subscriber may select to enroll in a newly available plan.
c. As used in this subsection the term "public school district" shall be interpreted to not include charter schools and educational service districts.
5. Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
6. Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber moves and their current health plan is not available in the new location, the subscriber must select a new health plan otherwise there will be limited accessibility to network providers and covered services;

7. A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);
8. Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or the subscriber's dependent loses eligibility for coverage under Medicaid or CHIP;
9. Subscriber or their dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP;
10. Subscriber or their dependent enrolls in coverage under Medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicare. If the subscriber's current medical plan becomes unavailable due to the subscriber's or a subscriber's dependent's enrollment in Medicare, the subscriber must select a new health plan;
11. Subscriber or their dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA); or
12. Subscriber or their dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or their dependent for a specific condition or ongoing course of treatment. The subscriber may not change their health plan election if the subscriber or a subscriber's dependent physician stops participation with the subscriber's health plan unless the SEBB Program determines that a continuity of care issue exists. The SEBB Program will consider but is not limited to considering the following: a. Active cancer treatment such as chemotherapy or radiation therapy;
b. Treatment following a recent organ transplant;
c. A scheduled surgery;
d. Recent major surgery still within the postoperative period; or
e. Treatment of a high risk pregnancy.

NOTE: If an enrollee's provider or vision care facility discontinues participation with the vision plan, the enrollee may not change vision plans until the SEBB Program's next annual open enrollment or when another qualifying event occurs that creates a special open enrollment, unless the SEBB Program determines that a continuity of care issue exists. This plan cannot guarantee that any provider orfacility will be available or remain under contract with us.

When may a subscriber enroll or remove eligible dependents?

Any one of the following events may create a special open enrollment:
1. Subscriber gains a new dependent due to:
a. Marriage or registering a state-registered domestic partnership;
b. Birth, adoption or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.

2. Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the HIPAA;
3. Subscriber has a change in employment status that affects the subscriber's eligibility for the employer contribution toward their employer-based group health plan; 4. The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
5. Subscriber or a subscriber's dependent has a change in enrollment under another employer-based group health insurance plan during its annual open enrollment that does not align with the SEBB Program's annual open enrollment;
6. Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence results in the dependent losing their health insurance;
7. A court order requires the subscriber, or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);

8. Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP) program, or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicaid or CHIP; or
9. Subscriber or their dependent becomes eligible for a state premium assistance subsidy for SEBB health plan coverage from Medicaid or CHIP.

When vision coverage ends

Vision coverage ends on the following dates:
1. The SEBB Organization terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the employer-initiated termination notice is effective;
2. The school employee terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the school employee's resignation is effective; or
3. The school employee's work pattern is revised such that the school employee is no longer anticipated to work six hundred thirty (630) hours during the school year. In this case, eligibility for the employer contribution ends as of the last day of the month in which the change is effective.

Premium payments and applicable premium surcharges become due the first of the month in which vision coverage is effective. Premium payments and applicable premium surcharges are not prorated during any month, even if an enrollee dies or asks to terminate their vision plan before the end of the month.
When vision plan enrollment ends, the enrollee may be eligible for continuation coverage if they apply within the timelines explained in the "Options for continuing SEBB vision coverage" on page 15.

If a subscriber enrolls in continuation coverage, the subscriber is responsible for timely payment of premiums and applicable premium surcharges. If the monthly premium or applicable premium surcharge remains unpaid for 30 days, it will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premium or applicable premium surcharge becomes delinquent to pay the unpaid premium balance or applicable premium surcharge. If the subscriber is not eligible for the employer contribution and has premium balance or applicable premium surcharge remains unpaid for 60 days from the original due date, the subscriber's vision coverage (including enrolled dependents) will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharge was paid.
A school employee who needs the required forms for an enrollment or benefit change may contact their SEBB Organization. All other subscribers may call the SEBB Program at the 1-800-200-1004.

Medicare eligibility and enrollment

If a school employee or their dependent becomes eligible for Medicare, they should contact the nearest Social Security Administration office to ask about the advantages of immediate or deferred Medicare enrollment.

Options for continuation of SEBB vision coverage

A school employee and their dependent covered by this vision plan has options for continuing insurance coverage during temporary or permanent loss of eligibility. There are two continuation coverage options for SEBB vision plan enrollees:
1. SEBB Continuation Coverage (COBRA)
2. SEBB Continuation Coverage (Unpaid Leave)

These two options temporarily extend group insurance coverage when the enrollee's SEBB vision plan coverage ends due to a qualifying event. SEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal law and regulation and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage. SEBB Continuation Coverage (Unpaid Leave) is an alternative created by the SEBB Program with wider eligibility criteria and qualifying event types. Enrollees who qualify for both types of SEBB Continuation Coverage (COBRA and Unpaid Leave) may choose to enroll in only one of the options.

“The enrollee’s election must be received by the SEBB Program no later than sixty days from the date the enrollee’s SEBB health plan coverage ended or from the postmark date on the election notice sent by the SEBB Program, whichever is later. The enrollee’s first premium payment and applicable premium surcharges are due no later than forty-five days after the election period ends as described in the prior sentence. Payment of premium and applicable premium surcharges associated with continuing SEBB health plan coverage must be made to the HCA.”

You must notify the SEBB Program in writing within 30 days if, after electing COBRA, you or your dependent become enrolled in Medicare (Part A, Part B, or both) or become covered under other group health plan coverage. If a subscriber enrolls in COBRA and then become eligible for Medicare, their enrollment in COBRA coverage will be terminated when the subscriber is eligible for Medicare. This may cause the COBRA coverage to be terminated early, before the subscriber has used all the months they would otherwise be entitled to. Subscribers who are already enrolled in Medicare when they enroll in COBRA will not have their coverage terminated early.

The SEBB Program administers both continuation coverage options. Refer to the *SEBB Continuation Coverage Election Notice* for details.

Option for Coverage under Public Employees Benefits Board (PEBB) Retiree Insurance

A retiring employee is eligible to continue enrollment or defer enrollment in Public Employees Benefits Board (PEBB) insurance coverage as a retiree if they meet procedural and substantive eligibility requirements. See the *PEBB Retiree Enrollment Guide* for details.

Transitional continuation coverage

School employees and their dependents may gain temporary eligibility for School Employees Benefits Board (SEBB) benefits, on a self-pay basis, if they meet the following criteria:
1. A school employee and their dependents who are enrolled in medical, dental, or vision under a group plan offered by a SEBB Organization on December 31, 2019, who lose eligibility because the school employee is not eligible for SEBB benefits, may elect to enroll in one or more of the following SEBB benefits: medical, dental, or vision coverage. These benefits will be provided for a maximum of eighteen months.
2. A dependent of a SEBB eligible school employee who is enrolled in medical, dental, or vision under a school employee's account on December 31, 2019, who loses eligibility because they are not an eligible dependent may enroll in medical, dental, and vision for a maximum of thirty-six months.
3. A dependent of a school employee who is continuing medical, dental, or vision coverage through a SEBB Organization on December 31, 2019, may elect to finish out their remaining months, up to the maximum number of months authorized by Consolidated Omnibus Budget Reconciliation Act (COBRA) for a similar event, by enrolling in a medical, dental, or vision plan offered through the SEBB Program**.**

Family and Medical Leave Act of 1993

A school employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward SEBB benefits in accordance with the FMLA. The SEBB Organization determines if the school employee is eligible for leave and the duration of the leave under FMLA. The school employee must continue to pay the school employee monthly premium contribution and applicable premium surcharge during this period to maintain eligibility.
If a school employee exhausts the period of leave approved under FMLA, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharge set by the Health Care Authority (HCA), with no contribution from the SEBB Organization while on approved leave. For additional information on continuation coverage, see the section titled “Options for continuing SEBB medical coverage.”

Paid Family Medical Leave Act

A school employee on approved leave under the Washington state Paid Family and Medical Leave Program may continue to receive the employer contribution toward SEBB benefits in accordance with the Paid Family and Medical Leave Program. The Employment Security Department determines if the school employee is eligible for the Paid Family and Medical Leave Program. The school employee must continue to pay the school employee monthly premium contribution and applicable premium surcharge during this period to maintain eligibility. If a school employee exhausts the period of leave approved under the Paid Family and Medical Leave Program, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharge set by HCA, with no contribution from the SEBB Organization while on approved leave. For additional information on continuation coverage, see the section titled “Options for Continuing SEBB Medical Coverage” page 15.

General provisions

Payment of premium during a labor dispute
Any school employee or dependent whose monthly premiums are paid in full or in part by the SEBB Organization may pay premiums directly the Health Care Authority (HCA) if the school employee’s compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

While the school employee’s compensation is suspended or terminated, HCA shall notify the school employee immediately by mail to the last address of record, that the school employee may pay premiums as they become due.

Appeal rights
Any current or former school employee of a SEBB Organization or their dependent may appeal a decision made by the SEBB Organization regarding SEBB eligibility, enrollment, or premium surcharges to the SEBB Organization.

Any enrollee may appeal a decision made by the SEBB Program regarding SEBB eligibility, enrollment, premium payments, or premium surcharges to the SEBB Appeals Unit.

Any enrollee may appeal a decision regarding the administration of SEBB vision by following the appeal provisions of the plan, with the exception of eligibility, enrollment, and premium payment decisions.

Relationship to law and regulations
Any provision of this certificate of coverage that is in conflict with any governing law or regulation of the state of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

TERMINATION OF INSURANCE

Please read the Continuation of Insurance section of this Policy for information on continuation after eligibility for coverage would otherwise end.

The Insurance on a Covered Person will end on the earliest date below:

1. The first of the month following the date this Policy or Insurance for a Covered Class is terminated; or

2. The day following the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy; or

3. The last day of the last period for which premium is paid; or

4. The day he reports for active duty in the armed forces of the United States or any other country; or

5. The end of any period of continuation, as provided by the Policyholder's personnel practices; or

6. With respect to a Dependent, the first day of the month following the date of the death of the Member or first day of the month following the date the Dependent is no longer in a Covered Class or satisfies eligibility requirements under this Policy; or

7. The first day of the month following the date the Employee retires from active service with the Policyholder.

Termination will not affect a claim for benefits incurred while coverage was in effect.

REINSTATEMENT

If Insurance ends because you become a full time member of the armed forces of the United States you will not have to satisfy any applicable Waiting Period provided you re-enroll yourself and your Dependents and return to Active Service after you leave active military service within the applicable time period specified in the Uniform Services Employment and Reemployment Rights Act (USERRA). If you do not re-enroll yourself and your Dependents within 31 days of the date you return to Active Service from a military leave you must wait until the next Enrollment Period or a Life Event to enroll.

If a Dependent's Insurance ends because he becomes a full time member of the armed forces of the United States that person may be re-enrolled if eligible provided he is re-enrolled within the applicable time period specified in the Uniform Services Employment and Reemployment Rights Act (USERRA). If you do not re-enroll this person within 31 days you must wait until the next Enrollment Period or a Life Event to enroll this person.

EXCLUSIONS

Benefits will not be paid for, and the term "Covered Expenses" will not include charges arising from:

1. Any Covered Expense not shown in the Schedule of Benefits or any expenses shown as "Not Covered" in the Schedule of Benefits.

2. Eye examinations required by an employer as a condition of employment except, as otherwise provided under the Safety Program.

3. Services or Materials provided in connection with special procedures such as orthoptics and visual training (including but not limited to "Corneal Refractive Therapy" ("CRT), or "orthokeratology"), or in connection with medical or surgical treatment (including laser vision correction) except as provided herein.

4. Materials which do not provide vision correction, except as provided herein.

5. Charges for the replacement of lost or stolen lenses or frames within the applicable benefit Frequency period in the Schedule of Benefits.

6. Sickness or injury covered by a workers' compensation act or other similar legislation.

7. Incurred as a direct or indirect result or war (declared or undeclared).

8. Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.

9. Services or supplies furnished to a Covered Person before the effective date of his Insurance under the Policy or after the date a Covered Person's Insurance ends.

10. Any medical treatment rendered outside the United States or Canada.

11. Services rendered by practitioners who do not meet the definition of Provider.

12. Comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior approval was not obtained from us or our authorized representative.

13. For Visually Required contact lenses prescribed for a Covered Person for which prior approval was not obtained from us or our authorized representative.

14. Refraction-only claims.

CLAIM PROVISIONS

In-Network

A Covered Person must contact an In-Network Provider before receiving services for a Covered Expense. The In-Network Provider will verify his eligibility for Covered Expenses with us or our authorized representative before the examination takes place. The Provider will submit Covered Person's claim directly to us or our authorized representative.

Out-of-Network

When a Covered Person uses an Out-of-Network Provider he must first pay the billed charge and then submit a claim.

1. Notice of Claim - written or authorized electronic/telephonic notice of claim must be given to us within 20 days after a Covered Expense is incurred or as soon as reasonably possible.

   Out of network claims should be mailed to:

   Davis Vision
   Vision Care Processing Unit
   P.O. Box 1525
   Latham, NY 12110

   This information is available via the website, claim form and customer service.

If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized representative. Notice should include the Policyholder's name and the Covered Person's name, address, Policy and Policy Number.

2. Claim Forms - we will send claim forms for filing proof of loss when we receive notice of a claim. If such forms are not provided within 15 days after we receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

3. Proof of Loss - written or authorized electronic proof of loss satisfactory to us must be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized representative within 90 days of the loss for which claim is made.

If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which we are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to lack of legal capacity.

4. Payment of Claims - we will pay benefits due under this Policy for any loss immediately upon receipt of due written or authorized electronic proof of such loss.

   All benefits will be paid in United States currency. All benefits payable under this Policy, unless otherwise stated, will be payable to the Covered Person or to his estate.

   If we are to pay benefits to the Covered Person's estate or to a person who is incapable of giving a valid release, we may pay up to $1,000 to a relative by blood or marriage that we believe is equitably entitled. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment and release us from all liability.

Right to Receive and Release Needed Information

We have the right to obtain or give information needed to coordinate benefit payments with other plans. This can be from or to any other insurance company, organization or person, subject to the consent of the Covered Person. Any Covered Person claiming benefits must furnish us with the necessary information needed to coordinate benefit payments.

Right to Make Payments

We have the right to pay any other organization, as needed, to properly carry out this provision. Any such payments made in good faith are considered benefits paid under the Policy, and fully discharge our liability, to the extent of such payments.

Right to Recovery

We have the right to retrieve any excess amounts that may have been paid out should they exceed the provisions of the Policy. This can be from the Covered Person for whom the payments were made. It can also be from any other insurance company or organization.

Review

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;

2. Reference to specific Certificate provisions, rules or guidelines on which the denial was based;

3. A description of the additional information needed to support your claim;

4. Information concerning your right to request that we review our decision; and

5. A description of our review procedures, time limits and notice of your right to bring civil action.

This request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. As part of this review, you may:

1. Send us written comments;

2. Review any non-privileged information relating to your claim; or

3. Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. A claim dispute may be sent to:

Davis Vision
Complaints and Appeals Department
P.O. Box 791
Latham, NY 12110

We will advise you of the results of our review within 60 days after we receive your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

Claimant Cooperation

Failure of a claimant to cooperate with us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Administration

The Policyholder has given us the authority to review claims for the benefits provided by this Policy and for deciding appeals of denied claims. In deciding appeals of denied claims, it will be necessary to interpret the terms of the Policy, to decide questions of eligibility for coverage or benefits under the plan, and to make any related findings of fact, as permitted by state and federal law.

We will have no responsibility with respect to the administration of the benefit provided by this Policy except as described above. It is understood that our sole liability to the Policyholder and Covered Persons under the Policy shall be for the payment of benefits provided under this Policy.

We may contract with another entity to perform this function on our behalf.

Legal Actions

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment

If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods:

1. A request for lump sum payment of the overpaid amount.

2. A reduction of any amounts payable under this Certificate.

If there is an overpayment due when the Covered Person dies, we may recover the overpayment from the Covered Person's estate.

ADMINISTRATIVE PROVISIONS

Direct Billing

If you are being billed directly you will receive a request for payment from us or our authorized representative on or before the premium due date. The premium due date will be shown on the request for payment. You should pay the amount due on or before the premium due date. Payment of the entire premium as it becomes due will maintain the Covered Person's Insurance in force through the date immediately before the next premium due date.

There is a 31 day grace period for remittance of premium billed directly. If you do not pay the premium on or before the premium due date, you may pay the premium during this 31 day period. A Covered Person's Insurance under the group Policy will remain in force during the grace period. If premium is not remitted before the end of the grace period, the Covered Person's Insurance will terminate automatically at 12:01 A.M. on the last day for which premium was paid.

Termination of a Covered Person's Insurance for nonpayment of premiums billed directly will not influence a Covered Person's right to a claim for benefits which arose prior to the termination. Our liability under the Policy is limited to benefits payable for eligible claims incurred prior to the date of termination.

Strike, Lockout and Labor Dispute

Any school employee or dependent whose monthly premiums are paid in full or in part by the SEBB Organization may pay premiums directly to the plan or the Health Care Authority (HCA) if the school employee's compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or any other labor dispute for a period not to exceed six months.

While the school employee's compensation is suspended or terminated, HCA shall notify the school employee immediately by mail to the last address of record, that the school employee may pay premiums as they become due.

During that period of time the Policy may not be altered or changed. Nothing in this section shall be deemed to impair the right of the Insurer to make normal decreases or increases of the premium rate upon expiration and renewal of the Policy, in accordance with the provisions of the Policy. Thereafter, if such insurance coverage is no longer available, then the Employee shall be given the opportunity to purchase an individual policy at a rate consistent with rates filed by the Insurer with the commissioner. When the Employee's compensation is so suspended or terminated, the Employee shall be notified immediately by the Policyholder in writing, by mail addressed to the address last on record with the Policyholder, that the Employee may pay the premiums to the Policyholder as they become due as provided in this section.

GENERAL PROVISIONS

Assignment

The rights and benefits under this Policy may be assigned under certain circumstances. Any Covered Person that wants to make an assignment of his Insurance should see the Policyholder for the conditions and further information.

We assume no responsibility for the validity, sufficiency, or effect of any assignment of a Covered Person's Insurance (including an assignment on a form furnished by us or by the Policyholder).

Incontestability

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of a claimant's death or incapacity, his applicable representative shall be given a copy.

After two years from a Covered Person's effective date of Insurance, or from the effective date of increased benefits, no such statement will cause Insurance or the increased benefits to be contested except for fraud.

Clerical Error

A Covered Person's Insurance will not be affected by clerical error or delay in keeping records of Insurance under the Policy. If such error or delay is found, we will adjust the premium fairly.

Relationship to Law and Regulations

Any provision of this certificate of coverage that is in conflict with any governing law or regulation of the state of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

Compensation Insurance

The Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation, Occupational Disease or similar law.

Coordination of Benefits

1. Notice to Covered Person(s)

If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.

CAUTION: All health plans have timely claim filing requirements. If you or your provider fail to submit your claim to a secondary health 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 health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent 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 and plans any changes in your coverage.

2. General

This Coordination of Benefits ("COB") provision applies to This Plan when a Covered Person has vision coverage under more than one plan. "Plan" and "This Plan" are defined below. If this COB provision applies, you should look first at the order of benefit determination rules. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan: (i) will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but (ii) may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in 5, "Effect on the Benefits of This Plan."

3. Definitions

"Plan" means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.

(a) If a plan coordinates benefits, its contract must state the types of coverage that will be considered

in applying the COB provision of that contract. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in this subsection.

(b) **"Plan"** means any of the following which provides benefits or services for, or because of vision care or treatment:
(1) Group insurance or group-type coverage; individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care;
(2) Coverage under Medicare or any other federal governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
(3) "Plan" does not include hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage as defined in WAC 284-50-370, or school accident and similar coverages that cover students for accidents only, including athletic injuries, either on a 24 hour basis or on a “to and from” school basis, “Plan” also does not include benefits provided in long-term insurance policies for nonmedical services (for example: personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care), contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services, Medicare supplement policies, a government plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan, automobile insurance policies required by statute to provide medical benefits, or benefits provided as part of a direct agreement with a direct patient-provider primary care practice. Each contract or other arrangement for coverage under (1) or (2) is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each part is a separate plan.

b. **"This Plan"** is the part of the Group Policy that provides benefits for vision care expenses.

c. **"Primary Plan/Secondary Plan":** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans and may be a Secondary Plan as to a different plan or plans.

d. **"Allowable Expense"** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense.
The following are examples of expenses that are not Allowable Expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
(3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. Order of Benefit Determination Rules

a. When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

(1) The primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

(2) Except as provided in subsection (3), a Plan that does not contain a coordination of benefits provision that is consistent with this section is always primary unless the provisions of both Plans state that the complying Plan is primary.

(3) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provide that this supplementary coverage is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(4) A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

b. This Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent – The Plan that covers the person other than as a Dependent, for example as an Employee, Member or Policyholder is the primary Plan and the Plan that covers the person as a Dependent is the secondary Plan. However, if a person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a Dependent, and primary to the Plan covering the person as other than a Dependent, then the order of benefits between the two Plans is reversed, so that the Plan covering the person as an Employee, Member or Policyholder is the secondary Plan and the other Plan is the primary Plan.

(2) Dependent Child Covered Under More Than One Plan – Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:

1. The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan; or
2. If both parents have the same birthday, the Plan that has covered the parent the longest is the primary Plan.

(b) For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;
2. If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for health care expenses, the Plan of the parent assuming financial responsibility is primary;
3. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;
4. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expense or health care coverage of the Dependent

child, the provisions of subsection (a) above determine the order of benefits; or

5. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

   i. The Plan covering the custodial parent, first;
   ii. The Plan covering the spouse of the custodial parent, second;
   iii. The Plan covering the non-custodial parent, third; and then
   iv. The Plan covering the spouse of the non-custodial parent, last.

(c) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subsection (a) or (b) above determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee – The Plan that covers a person as an active Employee, that is an Employee who is neither laid off nor retired, is the primary Plan. The Plan covering that same person as a retired or laid-off Employee is the secondary Plan. The same would hold true if a person is a Dependent of an active Employee and that same person is a Dependent of a retired or laid-off Employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does apply if the rule under section (b)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage – If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an Employee, Member, subscriber or retiree or covering the person as a Dependent of an Employee, Member, subscriber or retiree is the primary Plan and the COBRA or state or other federal continuation coverage is the secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section (b)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage – The Plan that covered the person as an Employee, Member, Policyholder, subscriber or retiree longer is the primary Plan and the Plan that covered the person the shorter period of time is the secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

5. Effect on the Benefits of This Plan

When **this plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **plans** during a claim determination period are not more than the total **allowable expenses.** In determining the amount to be paid for any claim, the **secondary plan** must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total **allowable expense** for that claim **total allowable expense** is the highest **allowable expense** of the **primary plan** or the **secondary plan.** In addition, the **secondary plan** must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

6. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules; we have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to pay the claim.

7. Facility of Payment

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

8. Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of:

a. the persons it has paid or for whom it has paid;
b. another plan; or
c. the provider of service.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services