blue of california

Eye Exam Only

BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY

CERTIFICATE OF INSURANCE

Trader Joe's Company
Group Number: W0069783-V0000579
Effective Date: July 1, 2023

Blue Shield of California Life & Health Insurance Company
601 12th Street, Oakland, CA 94607
blueshieldca.com

Blue Shield of California

Life & Health Insurance Company

(Blue Shield Life)

Certificate of Insurance

Eye Exam Only

Note: The name of the vision Plan describes an examination fee, a Materials Copayment, and a frame Allowance, and, if applicable, a contact lens Allowance. For example, "Enhanced Vision 15/25/150/120" means $15 for the exam Copayment/$25 for the Materials Copayment/$150 Allowance for frames//$120 Allowance for contact.

IMPORTANT NOTICE

No Insured has the right to receive the Benefits of this Policy for services or supplies furnished following termination of coverage, except as specifically provided in the Continuation of Group Coverage section of this Policy and the Certificate of Insurance. Benefits of this Policy are available only for services and supplies as included in the applicable sections of the Certificate of Insurance, furnished during the term the Policy is in effect and while the individual claiming Benefits is actually covered by this Policy. Benefits may be modified during the term of this Policy as specifically provided under the terms of this Certificate, the Group Policy or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for services or supplies furnished on or after the effective Date of modification. There is no vested right to receive the Benefits of this Plan.

This Certificate of Insurance replaces any other certificate previously issued for the Benefits described inside. As a Certificate of Insurance, this does not constitute a contract of insurance; it summarizes the provisions of the Policy and is subject to the terms of the Policy.

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DEFINITIONS

Whenever the following definitions are capitalized in this booklet, they will have the meaning stated below.

Active Work (Actively At Work) — your full-time performance of the customary duties of your occupation at the Group Policyholder's place of business (or other business location to which the Group Policyholder requires you to travel).

Allowable Amount — the maximum amount Blue Shield Life will pay for Covered Services, or the provider's billed charge for those Covered Services, whichever is less. Unless specified for a particular service elsewhere in this Policy, the Allowable Amount is:

1. For a Participating Provider: the amount the Participating Provider and the contracted VPA have agreed by contract will be accepted as payment in full for the service(s) rendered; or

2. Non-Participating Provider: the amount is the lesser of the billed charge or the Allowance for the Covered Service.

Allowance — A dollar amount available to apply towards Covered Services.

Blue Shield Life — Blue Shield of California Life & Health Insurance Company a corporation licensed as a life and disability insurer.

Copayment (Copay) — the amount that a person is required to pay for certain services after meeting any applicable deductible.

Day (Date) — at 11:59 P.M., Pacific Time, at the Group Policyholder's place of business (when used with regard to eligibility dates, effective dates, or termination of insurance).

Dependent —

(1) An Insured's legally married spouse who is not legally separated from the Insured; or,

(2) an Insured's Domestic Partner who is not covered for Benefits as an Insured; or,

(3) a child of, adopted by, or in legal guardianship of the Insured, spouse, or Domestic Partner. This category includes any stepchild or child placed for adoption or any other child for whom the Insured, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for Benefits as an Insured, who is less than 26 years of age, and who has been enrolled and accepted by Blue Shield Life as a Dependent and has maintained membership in accordance with the Policy.

(4) Note: Children of Dependent children (i.e., grandchildren of the Insured, spouse, or Domestic Partner) are not Dependents unless the Insured, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild. If coverage for a

Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled, Benefits for such Dependent will be continued upon the following conditions:

a. the child must be chiefly dependent upon the Insured, spouse, or Domestic Partner for support and maintenance;

b. the Insured, spouse, or Domestic Partner submits to Blue Shield Life a Physician's written certification of disability within 60 Days from the Date of the Group Policyholder's or Blue Shield Life's request; and

c. thereafter, certification of continuing disability and dependency from a Physician is submitted to Blue Shield Life on the following schedule:

(1) 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and

(2) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the Date when the Dependent child becomes ineligible for coverage under this Plan for any reason other than attained age.

A legally adopted child is considered the Employee's or the Employee spouse's or Domestic Partner's child from and after the moment the child is placed in the physical custody of the Employee, the Employee spouse, or the Domestic Partner for adoption.

The term Dependent does not include:

(1) anyone enrolled under the Policy as an Employee; or

(2) anyone serving in the armed forces of any state or country; except for duty of 30 Days or less for training in the reserves or National Guard.

Domestic Partner — an individual who is personally related to the Insured by a domestic partnership that meets the following requirements:

(1) Both partners are 18 years of age or older, except as provided in Section 297.1 of the California Family Code;

(2) The partners have chosen to share each other's lives in an intimate and committed relationship of mutual caring;

(3) The partners are (a) not currently married to someone else or a member of another domestic partnership, and (b) not so closely related by blood that legal marriage or registered domestic partnership would otherwise be prohibited;

(4) Both partners are capable of consenting to the domestic partnership; and

(5) If required under your Employer's written policy, both partners must file a Declaration of Domestic Partnership with the California Secretary of State, pursuant to the California Family Code.

The domestic partnership is deemed created on the date when both partners meet the above requirements.

Elective Contact Lenses — lenses that are chosen for cosmetic or convenience purposes. Elective contact lenses are not, medically necessary.

Employee — an individual who meets the eligibility requirements set forth in the Group Vision Policy between Blue Shield Life and your Employer.

Group Policyholder — the person, partnership, corporation, trust, or association as shown on the title page of this Certificate.

Insurance Month — that period of time:

(1) beginning at 12:01 A.M. Pacific Time, at the Group Policyholder's place of business on the first Day of any calendar month; and

(2) ending at 11:59 P.M. Pacific Time on the last Day of the same calendar month.

Insured — an Employee or Dependent who has completed an enrollment form approved by Blue Shield Life and for whom coverages provided by this Policy are in effect.

Materials — any type of lenses, including contact lenses (Medically Necessary or Elective), frames, and low vision aids.

Non-Elective (Medically Necessary) Contact Lenses — lenses following cataract surgery, or when contact lenses are the only means to correct visual acuity to 20/40 for keratoconus or 20/60 for anisometropia, or for certain conditions of myopia (12 or more diopters), hyperopia (7 or more diopters) or astigmatism (over 3 diopters).

Non-Participating Provider — a licensed ophthalmologist, optometrist or dispensing optician who has not signed a service contract with the contracted VPA.

Participating Provider — refers to a licensed ophthalmologist, optometrist or dispensing optician who has signed a service contract with the contracted VPA.

Plan — The Vision Plan indicated on the cover of this document.

Policy — group insurance policy issued by Blue Shield Life to the Group Policyholder.

Vision Plan Administrator (VPA) — Blue Shield of California Life & Health Insurance Company has contracted with the Plan's Vision Plan Administrator (VPA). The contracted VPA is a vision care service plan licensed by the California Department of Insurance, which contracts with Blue Shield Life to administer delivery of eyewear and eye exams covered under this Vision Plan through a network of Participating Providers. The contracted VPA also contracts with Blue Shield Life to serve as a claims administrator for the processing of claims for services received from Non-Participating Providers.

Vision Plan Information Card — A card mailed to the Subscriber that is not required to access care and is not a verification of eligibility in the vision Plan. The Vision Plan Information Card contains telephone numbers, a website address, and other information to assist the Insured and providers in obtaining Benefit information, as well as verifying eligibility in the vision Plan.

VISION PLAN PROVIDERS AND ADMINISTRATION

The Blue Shield Life Vision Plan is administered by the contracted VPA. The contracted VPA makes available a contracted network of Participating Providers and administers claims on Blue Shield Life's behalf for the services and materials covered under this Policy. The contracted VPA can be contacted through customer service as provided in the Certificate of Insurance.

Participating Providers may be found through an online directory at www.blueshieldca.com or by contacting Customer Service as provided in the Certificate of Insurance.

ELIGIBILITY AND EFFECTIVE DATES FOR YOUR VISION INSURANCE

Eligibility and Enrollment.

To enroll and continue enrollment, a Subscriber must be an eligible Employee and meet all of the eligibility requirements for coverage established by the Group Policyholder. An Employee is eligible for coverage as a Subscriber the Day following the Date he or she completes the waiting period established by the Group Policyholder.

The Group Policyholder must meet specified Group Policyholder eligibility, participation and contribution requirements to be eligible for this group Plan. If the Group Policyholder fails to meet these requirements, this coverage will terminate. See the *Termination of Your Vision Insurance* section of this Certificate for further information. Employees will receive notice of this termination and, at that time, will be provided with information about other potential sources of coverage.

Subject to the requirements described under the Continuation of Group Coverage provision in this Certificate, if applicable, an Employee and his or her Dependents will be eligible to continue group coverage under this Plan when coverage would otherwise terminate.

EFFECTIVE DATE. Vision insurance for an Employee becomes effective on the latest of:

(1) the Date you become eligible for the coverage;
(2) the Date you resume Active Work, if not Actively at Work on the Day you became eligible; or
(3) the Date you submit a completed enrollment form, if any part of the premium for the Policy is paid by you.

ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT VISION INSURANCE

ELIGIBILITY. Your Dependent becomes eligible for coverage on the latest of:

(1) the Date you become eligible for coverage; or
(2) the Date you first acquire a Dependent.

EFFECTIVE DATE. Your Dependent's coverage will become effective on the Date you submit a completed enrollment form.

LATE ENROLLMENT FOR EMPLOYEES AND DEPENDENTS

When an Employee declines coverage for oneself or that Employee's Dependents during the initial enrollment period and later requests enrollment, an Employee and the Employees Dependents will be eligible the earlier of 12 months from the Date of the request for enrollment or at the Group Policyholder's next open enrollment period. The Group Policyholder is responsible for submitting only those Employees and Dependents who meet the eligibility requirements. Blue Shield of California Life & Health Insurance Company will not consider applications for earlier effective Dates.

An Employee and the Employee's Dependents will not be considered ineligible for enrollment if the following applies:

(1) The Employee or the Employee's Dependents lose coverage under a previous employer's plan and apply for coverage under this Plan within 31 Days of the Date of loss of coverage. An Employee will be required to furnish to Blue Shield Life written proof of the loss of coverage.
(2) Newborn infants of the Insured, spouse, or Domestic Partner will be eligible immediately after birth for the first 31 Days.
(3) A child placed for adoption will be eligible immediately upon the Date the Insured, spouse or Domestic Partner has the right to control the child's health care. Enrollment requests for children who have been placed for adoption must be accompanied by evidence of the Insured's, spouse's or Domestic Partner's right to control the child's health care. Evidence of such control includes a health facility minor release report, a medical authorization form or a relinquishment form. In order to have coverage continue beyond the first 31 Days without lapse, an application must be submitted to and received by Blue Shield Life within 31 Days from the Date of birth or placement for adoption of such Dependent.
(4) A child acquired by legal guardianship will be eligible on the Date of the court ordered guardianship, if an application is submitted within 31 Days of becoming eligible.
(5) If a court has ordered the Insured to provide coverage for your spouse, Domestic Partner or Dependents under the Plan, their coverage will become effective within 31 Days of presentation of a court order or request by a custodial party, as described in Section 3751.5 of the California Family Code.
(6) You may add newly acquired Dependents and yourself to the Plan by submitting an application within 31 Days from the Date of acquisition of the Dependent:
    1. to continue coverage of a newborn or child placed for adoption;
    2. to add a spouse after marriage or add a Domestic Partner after establishing a domestic partnership;
    3. to add yourself and Spouse following the birth of a newborn or placement of a child for adoption;
    4. to add yourself and spouse after marriage;
    5. to add yourself and your newborn or child placed for adoption, following birth or placement for adoption.

Coverage is never automatic; an application is always required.

If both partners in a marriage or Domestic Partnership are eligible to be the Insured, then they are both eligible for Dependent benefits. Their children may be eligible and may be enrolled as a Dependent of both parents.

Enrolled Dependent children who would normally lose their eligibility under this Plan solely because of age, but who are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, may have their eligibility extended under the following conditions:

(1) the child must be chiefly dependent upon the Employee for support and maintenance, and
(2) the Employee must submit a physician's written certification of such disabling condition. Blue Shield Life or the Group Policyholder will notify you at least 90 Days prior to the Date the Dependent child would otherwise lose eligibility.

TERMINATION OF YOUR VISION INSURANCE

Your coverage will terminate on the earliest of:

(1) the Date the Policy is terminated;
(2) the last Day of the Insurance Month in which you request termination;
(3) upon expiration of the 31-Day grace period following notice of termination for nonpayment of premium;
(4) the Date you cease to be in a class of Employees which is eligible for coverage under the Policy;
(5) with respect to any particular insurance Benefit, the Date that portion of the Policy providing such Benefit terminates;
(6) [the Date on which] your employment (or membership, as applicable) with the Group Policyholder terminates; or
(7) the Date you enter the armed services of any state or country on active duty; except for duty of 30 Days or less for training in the reserves or national guard.

Ceasing Active Work is deemed termination of employment and results in termination of coverage, except as follows:

(1) If you are disabled due to illness or injury, then coverage may be continued during the disability for up to 12 months, provided premium payments are made on your behalf.
(2) If the Active Work ceases due to a temporary layoff, an approved leave of absence, or a military leave, then coverage may be continued three (3) Insurance Months after the lay off or leave began (provided premium payments are being made on your behalf.)

FAMILY CARE LEAVE

If the Group Policyholder is subject to the California Family Rights Act of 1991 and/or the Federal Family & Medical Leave Act of 1993 and your approved leave of absence is for family care pursuant to such Act, payment of premiums for you shall keep coverage in effect for the duration(s) prescribed by the Acts. The Group Policyholder is solely responsible for notifying you of the availability and duration of family leaves.

TERMINATION OF DEPENDENT VISION INSURANCE

Insurance will cease for your Dependent(s) when:

(1) your vision insurance terminates;
(2) you request that the Dependent insurance be terminated; or
(3) a Dependent ceases to be a Dependent as defined in this Policy.

CONTINUATION OF INSURANCE DURING A LABOR DISPUTE

An Insured may continue coverage for as long as 6 months when:

(1) the Group Policyholder's premium contributions are required by a collective bargaining agreement; and
(2) your eligibility ends because your employment ceases due to a labor dispute.

Continued insurance will end on the earliest of:

(1) the Date insurance has been continued for 6 months;
(2) the Date you begin full-time employment with another employer;
(3) the Date fewer than 75% of the Insured full-time Employees eligible for this continuation are continuing their insurance;
(4) the end of the period for which the last premium has been paid; or
(5) the Date insurance would otherwise terminate, had you remained an active Employee.

MONTHLY PREMIUM. You must continue to pay the Group Policyholder the required monthly premium (including the part normally paid by the Group Policyholder). The monthly premium will be at the same rate Blue Shield Life would have charged for the coverage, if you had remained an active Employee. Blue Shield Life retains the right to adjust the rates during the continuation period.

ELECTION. To continue insurance, you must send the Group Policyholder:

(1) a written request to continue insurance; and
(2) the first monthly premium payment.

This must be done within 31 Days after your Active Work ceases due to a labor dispute. You may exercise the conversion privilege at any time during the period of continued coverage.

COVERED SERVICES AND SUPPLIES

Covered services are limited to:

(1) One (1) comprehensive eye examination in a consecutive 12-month period. A comprehensive examination represents a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service but need not be performed at one session. The service may include history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination for cycloplegia or mydriasis, tonometry and usually determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in presence of trauma or severe inflammation.

You are responsible for a Copayment for the annual comprehensive eye examination as stated in the Summary of Benefits.

(2) One (1) diabetes management referral per Calendar Year to a Blue Shield disease management program for Insureds enrolled in a Blue Shield of California or Blue Shield Life Medical Plan. The contracted VPA will notify Blue Shield Life disease management program, subsequent to the annual comprehensive eye exam, when you are known to have or be at risk for diabetes.

PAYMENT TO PARTICIPATING PROVIDERS. Blue Shield Life will pay for Covered Service rendered by Participating Providers up to the Allowable Amount.

PAYMENT TO NON-PARTICIPATING PROVIDERS. You or the provider must submit a completed claim form to Blue Shield Life. Refer to the claims procedures set forth under the section entitled, "Claims Procedures for Vision Insurance."

Payments for services of a Non-Participating Provider will be sent directly to you. You are responsible for the difference between the Non-Participating Provider's charges and the Allowance under the Summary of Benefits, as well as any applicable Copayment and charges for frame or lens styles above the Allowance.

CHOICE OF PROVIDERS. An Insured may select any licensed ophthalmologist, optometrist, or dispensing optician to provide Covered Services under this Benefit, including such providers outside of California. A directory of Participating Providers is available on Blue Shield Life's internet site located at http://www.blueshieldca.com. You may also obtain this information from the VPA by calling the telephone number listed in the Customer Service section of this COI.

INDEPENDENT CONTRACTORS. Providers are neither agents nor Employees of the Plan but are independent contractors. In no instance shall the Plan be liable for the negligence, wrongful acts, or omissions of any person providing services.

EXCEPTION FOR OTHER COVERAGE. Participating Providers may seek reimbursement from other third party payers for the balance of their reasonable charges for services rendered under this Plan.

REDUCTIONS – THIRD PARTY LIABILITY. The amount Blue Shield Life seeks as restitution, reimbursement, or other available remedy is against any recovery the Insured receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Insured has been "made whole" by the Recovery. The amount Blue Shield Life seeks as restitution, reimbursement or other available remedy will be calculated in accordance with California Civil Code section 3040.

GENERAL EXCLUSIONS. Unless exceptions to the following are specifically made elsewhere in this booklet, no Benefits are provided for:

(1) orthoptics or vision training, subnormal vision aids or non-prescription lenses for glasses when no prescription change is indicated;
(2) replacement or repair of lost or broken lenses, contact lenses, or frames except as provided under this Policy;
(3) any eye examination required by a Group Policyholder as a condition of employment;
(4) medical or surgical treatment of the eyes; or
(5) contact lenses, except as specifically provided; or
(6) refitting after the initial 90-day fitting period;
(7) artistically painted lenses;
(8) plano (non-prescription) lenses;
(9) services for or incident to any injury arising out of, or in the course of any employment for salary, wage or profit if such injury or disease is covered by workers' compensation law, occupational disease law or similar legislation. However, if Blue Shield Life provides payment for such services, it shall be entitled to establish a lien upon such other Benefits up to the amount paid by Blue Shield Life for the treatment of the injury or disease;
(10) services required by any government agency or program, Federal, state, or subdivision thereof;
(11) services and materials for which the Insured is not legally obligated to pay, or services or materials for which no charge is made to the Insured;
(12) services not specifically listed as a Benefit.

CLAIMS PROCEDURES FOR VISION INSURANCE

NOTICE OF CLAIM. In the event that a Participating Provider does not bill Blue Shield Life directly or when an Insured receives services from a Non-Participating Provider, notice of claim must be provided in writing within 20 Days, or as soon thereafter as is reasonably possible, after the Date of service occurs. The notice must be sent to:

Blue Shield Life at P.O. Box 25208, Santa Ana, CA 92799-5208

and should include:

(1) your name;
(2) your address; and
(3) the number of this Policy.

CLAIM FORMS. When notice of claim is received, Blue Shield Life will send you forms for filing the required proof of claim. If you do not receive these claim forms within 15 Days, an Insured may file a claim without using a claim form by sending Blue Shield Life written proof of claim as described below.

PROOF OF CLAIM. Written proof of claim must be given to Blue Shield Life within 90 Days after the Date of service. If it was not reasonably possible to give written proof in the time required, the claim will not be reduced or denied solely for this reason; provided proof is filed as soon as reasonably possible. The claim will be denied if submitted beyond one year from the time proof is required unless the claimant was legally incapacitated and could not notify Blue Shield Life.

TIME OF PAYMENT OF CLAIMS.Claims will be paid promptly upon receipt of proper written proof and determination that Benefits are payable.

LEGAL ACTIONS: No legal action to recover any Benefits may be brought until 60 Days after the required written proof of claim is given. No legal action may be brought more than three years after written proof of claim is required to be given.

CONTINUATION OF GROUP COVERAGE

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Applicable to the Insured when the Group Policyholder is subject to either Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended or the California Continuation Benefits Replacement Act (Cal-COBRA). The Group Policyholder should be contacted for more information.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended and the California Continuation Benefits Replacement Act (Cal-COBRA), an Insured will be entitled to elect to continue group coverage under this Policy if the Insured would otherwise lose coverage because of a Qualifying Event that occurs while the Group Policyholder is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA.

The Benefits under the group continuation of coverage will be identical to the Benefits that would be provided to the Insured if the Qualifying Event had not occurred (including any changes in such coverage).

Note: An Insured will not be entitled to Benefits under Cal-COBRA if at the time of the Qualifying Event such Insured is entitled to Benefits under Title XVIII of the Social Security Act ("Medicare") or is covered under another group health plan that provides coverage without exclusions or limitations with respect to any pre-existing condition. Under COBRA, an Insured is entitled to Benefits if at the time of the Qualifying Event such Insured is entitled to Medicare. However, if Medicare entitlement arises after COBRA coverage begins, it will cease.

QUALIFYING EVENT. A Qualifying Event is defined as a loss of coverage as a result of any one of the following occurrences.

(1) With respect to you as the Insured Employee:

   a. the termination of employment (other than by reason of gross misconduct); or
   b. the reduction of hours of employment to less than the number of hours required for eligibility.

(2) With respect to the Dependent spouse or Dependent Domestic Partner* and Dependent children (children born to or placed for adoption with the Insured Employee, or Employee's Dependent spouse or Domestic Partner, during a COBRA or Cal-COBRA continuation period may be immediately added as Dependents, provided the Group Policyholder is properly notified of the birth or placement for adoption, and such children are enrolled within 30 Days of the birth or placement for adoption):

   *Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Insured Employee elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

   a. the death of the Employee; or

   b. the termination of the Employee's employment (other than by reason of such Employee's gross misconduct); or

   c. the reduction of the Employee's hours of employment to less than the number of hours required for eligibility; or

d. the divorce or legal separation of the Employee from the Dependent spouse or termination of the domestic partnership; or

e. the Employee's entitlement to Benefits under Title XVIII of the Social Security Act ("Medicare"); or

f. a Dependent child's loss of Dependent status under the Policy.

(3) For COBRA only, with respect to an Employee who is covered as a retiree, that retiree's Dependent spouse and Dependent children, the Group Policyholder's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.

(4) With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA or Cal-COBRA.

NOTIFICATION OF A QUALIFYING EVENT

1. With respect to COBRA enrollees:

The Insured is responsible for notifying the Group Policyholder of divorce, legal separation, termination of a Domestic Partner or a child's loss of Dependent status under this Policy, within 60 Days of the Date of the later of the Qualifying Event or the Date on which coverage would otherwise terminate under this Policy because of a Qualifying Event.

The Group Policyholder is responsible for notifying its COBRA administrator (or Plan administrator if the Group Policyholder does not have a COBRA administrator) of your death, termination, or reduction of hours of employment, the Insured Employee's Medicare entitlement or the Group Policyholder's filing for reorganization under Title XI, United States Code.

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will, within 14 Days, provide written notice to the Insured by first class mail of his or her right to continue group coverage under this Policy. The Insured must then notify the COBRA administrator within 60 Days of the later of:

(1) the Date of the notice of the Insured's right to continue group coverage or (2) the Date coverage terminates due to the Qualifying Event.

If the Insured does not notify the COBRA administrator within 60 Days, the Insured's coverage will terminate on the Date the Insured would have lost coverage because of the Qualifying Event.

2. With respect to Cal-COBRA enrollees:

The Insured is responsible for notifying Blue Shield Life in writing of the Employee's death or Medicare entitlement, of divorce, legal separation, termination of a domestic partnership, or a child's loss of Dependent status under this Policy. Such notice must be given within 60 Days of the Date of the later of the Qualifying Event or the Date on which coverage would otherwise terminate under this Policy because of a Qualifying Event.

Failure to provide such notice within 60 Days will disqualify the Insured from receiving continuation coverage under Cal-COBRA.

The Group Policyholder is responsible for notifying Blue Shield Life in writing of termination or reduction of hours of employment within 30 Days of the Qualifying Event.

When Blue Shield Life is notified that a Qualifying Event has occurred, Blue Shield Life will, within 14 Days, provide written notice to the Insured by first class mail of his or her right to continue group coverage under this Policy. The Insured must then give Blue Shield Life notice in writing of the Insured's election of continuation coverage within 60 Days of the later of: (1) the Date of the notice of the Insured's right to continue group coverage, and (2) the Date coverage terminates due to the Qualifying Event. The written election notice must be delivered to Blue Shield Life by first-class mail or other reliable means.

If the Insured does not notify Blue Shield Life within 60 Days, the Insured's coverage will terminate on the Date the Insured would have lost coverage because of the Qualifying Event.

If this Policy replaces a previous group plan that was in effect with the Group Policyholder's, and the Insured had elected Cal-COBRA continuation coverage under the previous plan, the Insured may choose to continue to be covered by this Policy for the balance of the period that the Insured could have continued to be covered under the previous plan, provided that the Insured notify Blue Shield Life within 30 Days of receiving notice of the termination of the previous group plan.

DURATION AND EXTENSION OF CONTINUATION OF GROUP COVERAGE

Cal-COBRA enrollees will be eligible to continue Cal-COBRA coverage under this Policy for up to a maximum of 36 months regardless of the type of Qualifying Event.

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA, may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the Date the Insured's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends.

Note: COBRA enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of group coverage under COBRA, Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than 3 years from the Date the Qualifying Event has occurred which originally entitled the Insured to continue group coverage under this Policy. However, an Insured may qualify for continuation of group coverage after COBRA and/or Cal-COBRA.

Note: Domestic Partners and Dependent children of Domestic Partners cannot elect COBRA on their own, and are only eligible for COBRA if the Insured Employee elects to enroll. Domestic Partners and Dependent children of Domestic Partners may elect to enroll in Cal-COBRA on their own.

NOTIFICATION REQUIREMENTS. The Group Policyholder or its COBRA administrator is responsible for notifying COBRA enrollees of their right to possibly continue coverage under Cal-COBRA at least 90 calendar Days before their COBRA coverage will end. The COBRA enrollee should contact Blue Shield Life for more information about continuing coverage. If the enrollee elects to apply for continuation of coverage under Cal-COBRA, the enrollee must notify Blue Shield Life at least 30 Days before COBRA termination.

PAYMENT OF PREMIUMS. Premiums for the Insured continuing coverage shall be 102 percent of the applicable group premium rate if the Insured is a COBRA enrollee, or 110 percent of the applicable group premiums rate if the Insured is a Cal-COBRA enrollee, except for the Insured who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the premiums for months 19 through 29 shall be 150 percent of the applicable group premium rate.

Note: For COBRA enrollees who are eligible to extend group coverage under COBRA to 29 months because of a Social Security disability determination, premiums for Cal-COBRA coverage shall be 110 percent of the applicable group premiums rate for months 30 through 36.

If the Insured is enrolled in COBRA and is contributing to the cost of coverage, the Group Policyholder shall be responsible for collecting and submitting all premium contributions to Blue Shield Life in the manner and for the period established under this Policy.

Cal-COBRA enrollees must submit premiums directly to Blue Shield Life. The initial premiums must be paid within 45 Days of the Date the Insured provided written notification to Blue Shield Life of the election to continue coverage and be sent to Blue Shield Life by first-class mail or other reliable means. The premiums payment must equal an amount sufficient to pay any required amounts that are due. Failure to submit the correct amount within the 45-Day period will disqualify the Insured from continuation coverage.

EFFECTIVE DATE OF THE CONTINUATION OF COVERAGE. The continuation of coverage will begin on the Date the Insured's coverage under this Policy would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as premiums are timely paid.

TERMINATION OF CONTINUATION OF GROUP COVERAGE. The continuation of group coverage will cease if any one of the following events occurs prior to the expiration of the applicable period of continuation of group coverage:

(1) discontinuance of this group vision insurance Policy (if the Group Policyholder continues to provide any group Benefit plan for Employees, the Insured may be able to continue coverage with another plan);
(2) failure to timely and fully pay the amount of required premiums to the COBRA administrator or the Group Policyholder or to Blue Shield Life as applicable. Coverage will end as of the end of the period for which premiums were paid;
(3) the Insured becomes covered under another group health plan that does not include a pre-existing condition exclusion or limitation provision that applies to the Insured;

(4) the Insured becomes entitled to Medicare;
(5) the Insured no longer resides in California;
(6) the Insured commits fraud or deception in the use of the Benefits of this Policy.

Continuation of group coverage in accordance with COBRA or Cal-COBRA will not be terminated except as described in this provision. In no event will coverage extend beyond 36 months.

NOTIFICATION REQUIREMENTS. The Group Policyholder is solely responsible for notifying former Employees or Dependent spouses or Dependent Domestic Partners (including former spouses or former Domestic Partners as defined above) of the availability of the coverage at least 90 calendar Days before COBRA or Cal-COBRA is scheduled to end. To elect this coverage, the former Employee (and/or former spouse or former Domestic Partner) must notify Blue Shield Life in writing at least 30 calendar Days before COBRA or Cal-COBRA is scheduled to end.

COORDINATION OF BENEFITS

Coordination of Benefits is designed to provide maximum coverage for medical and hospital bills at the lowest cost by avoiding excessive payments.

When you or your Dependent who is covered under this Policy is also covered under another group policy or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of such arrangement whereby the members of a group are entitled to payment of or reimbursement for hospital or medical expenses, you or your Dependent will not be permitted to make a "profit" on a disability by collecting Benefits in excess of actual cost. Instead, payments will be coordinated between the policies in order to provide for "allowable expenses" (these are the expenses that are incurred for services and supplies covered under at least one of the policies involved) up to the maximum Benefit amount payable by each policy separately.

If you or your Dependent is also entitled to any Benefits under any of the conditions outlined under the "Exclusion for Duplicate Coverage" provision, Benefits received under any such condition will not be coordinated with the Benefits of this Policy.

The following rules determine the order of Benefit payments:

When the other plan does not have a coordination of benefits provision it will always provide its benefits first. Otherwise, the plan covering the patient as an Employee will provide its benefits before the plan covering the patient as a Dependent.

Except for cases of claims for a Dependent child whose parents are separated or divorced, the plan which covers the patient as a Dependent of a person whose Date of birth (excluding year of birth) occurs earlier in a Calendar Year shall determine its benefits before a plan which covers that patient as a Dependent of a person whose date of birth (excluding year of birth) occurs later in a Calendar Year. If either plan does not have the provisions of this paragraph regarding Dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph shall not apply,

and the rule set forth in the plan which does not have the provisions of this paragraph shall determine the order of benefits.

(a) In the case of a claim involving expenses for a Dependent child whose parents are separated or divorced, plans covering the child as a Dependent shall determine their respective benefits in the following order:

First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.

(b) Notwithstanding (a) above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a Dependent of the parent with that financial responsibility shall determine its benefits before any other plan which covers the child as a Dependent child.

(c) If the above rules do not apply, the plan which has covered the patient for the longer period of time shall determine its benefits first, provided that:

1. a plan covering a patient as a laid-off or retired Employee, or as a Dependent of such an Employee, shall determine its benefits after any other plan covering that person as an Employee, other than a laid-off or retired Employee, or such Dependent; and
2. if either plan does not have a provision regarding laid-off or retired Employees, which results in each plan determining its benefits after the other, then the provisions of (1) above shall not apply.

If Blue Shield Life is the primary carrier with respect to an Insured, then this Policy will provide its benefits without reduction because of benefits available from any other plan, except that Participating Providers may collect any difference between their billed charges and Blue Shield Life's payment from the secondary carrier(s).

When Blue Shield Life is secondary in the order of payments, and Blue Shield Life is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, Blue Shield Life will pay the benefits that would be due as if it were the primary plan, provided that the Insured: (1) assigns to Blue Shield Life the right to receive benefits from the other plan to the extent of the difference between the benefits which Blue Shield Life actually pays and the amount that Blue Shield Life would have been obligated to pay as the secondary plan, (2) agrees to cooperate fully with Blue Shield Life in obtaining payment of benefits from the other plan, and (3) allows Blue Shield Life to obtain conformation from the other plan that the benefits which are claimed have not previously been paid.

EXCLUSION FOR DUPLICATE COVERAGE

In the event that you are covered under this Policy and are also entitled to benefits under any of the conditions listed below, Blue Shield Life's liability as a secondary payor for Covered Services is limited to the patient's out-of-pocket expenses that do not exceed the total benefit under this Policy or the amount of Blue Shield Life's fee-for-service payment to the provider, whichever is less, so the total benefits paid or provided by all

policies during the policy year are not more than the total covered charges. This exclusion is applicable to benefits received from any of the following sources:

1. Benefits provided under Title XVIII of the Social Security Act (commonly known as Medicare). If an Insured receives services for which he is entitled to benefits under Medicare and those services are also covered under this Policy, the benefits of this Policy will be provided less the amount paid under Medicare. Any deductible or Copayment or coinsurance requirement of this Policy will be waived when Medicare is primary and the provider of services has accepted Medicare assignment. This exclusion for Medicare does not apply when the Group Policyholder is subject to the Medicare Secondary Payer laws and the Group Policyholder maintains:

   a. a group health plan that covers Insureds entitled to Medicare solely because of end-stage renal disease and active full-time Employees or spouses or Domestic Partners entitled to Medicare by reason of age; and/or

   b. a large group health plan as defined under the Medicare Secondary Payer laws that covers Insureds entitled to Medicare by reason of disability.

      This paragraph shall also apply to an individual who becomes eligible for Medicare benefits prior to age 65 but who had not enrolled under Medicare on the Date that he received notice of eligibility for such enrollment.

2. Any services, including room and board, provided by any other Federal or State governmental agency, or by any Municipality, County or other political subdivision, except that this exclusion does not apply to the Medi-Cal program, or Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code or for reasonable costs of services provided to the Insured at a Veterans' Administration facility for a condition unrelated to military service or at a Department of Defense facility, provided the Insured is not on active duty.

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

Blue Shield Life protects the confidentiality/privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, or Social Security Number. Blue Shield Life will not disclose this information without your authorization, except as permitted by law.

A STATEMENT DESCRIBING BLUE SHIELD LIFE'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Blue Shield Life's policies and procedures regarding our confidentiality/privacy practices are contained in the "Notice of Privacy Practices," which you may obtain either by calling the Customer Service Department at the number listed in the back of this booklet or accessing Blue Shield Life's Internet site located at http://www.blueshieldca.com and printing a copy.

If you are concerned that Blue Shield Life may have violated your confidentiality/privacy rights, or you disagree with a decision we made about access to your personal and health information, you may contact us at:

Correspondence Address:
Blue Shield Life Privacy Official
P. O. Box 272540
Chico, CA 95927-2540

Toll-Free Telephone Number:
1-888-266-8080

E-mail Address:
BlueShieldca_Privacy@blueshieldca.com

CONFIDENTIAL COMMUNICATION REQUESTS

A health plan shall notify Subscribers and enrollees that they may request a confidential communication pursuant to the following and how to make the request.

A health plan shall permit Subscribers and enrollees to request, and shall accommodate requests for, confidential communication in the form and format requested by the individual, if it is readily producible in the requested form and format, or at alternative locations.

A health plan may require the Subscriber or enrollee to make a request for a confidential communication in writing or by electronic transmission.

The confidential communication request shall be valid until the Subscriber or enrollee submits a revocation of the request or a new confidential communication request is submitted.

The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication.

A confidential communication request may be submitted in writing to Blue Shield Life at the mailing address, email address, or fax number below. A confidential communication form, available by going to blueshieldca.com/privacy and clicking on "privacy forms," may be used when submitting a confidential communication request in writing, but it is not required.

Once in place, a valid confidential communication request prevents Blue Shield from: 1. Requiring the protected individual to obtain the primary Subscriber's or other enrollee's authorization to receive sensitive services or submit a claim for sensitive services if the protected individual has the right to consent to care; and 2. Disclosing medical information relating to sensitive health services provided to a protected individual to the primary Subscriber or any plan enrollees other than the protected individual receiving care, absent an express written authorization of the protected individual receiving care.

You may return this completed and signed form via any of these options:

Mail: Blue Shield of California Privacy Office, P.O. Box 272540, Chico CA, 95927-2540

Email: privacy@blueshieldca.com

Fax: 1-800-201-9020

ACCESS TO INFORMATION

Blue Shield Life may need information from your medical or vision providers, from other carriers or other entities, or from you, in order to administer Benefits and eligibility provisions of this Policy. You agree that any provider or entity can disclose to Blue Shield Life that information that is reasonably needed by Blue Shield Life. You agree to assist

Blue Shield Life in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield Life with information in your possession. Failure to assist Blue Shield Life in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of Benefits until the necessary information is received. Any information received for this purpose by Blue Shield Life will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

CUSTOMER SERVICE

If you have a question about services, providers, Benefits, how to use this Policy, or concerns regarding the quality of care or access to care that you have experienced, you may contact Blue Shield Life's Customer Service Department at:

1-877-601-9083

Blue Shield of California Life & Health Insurance Company
P.O. Box 25208
Santa Ana, California 92799-5208

www.blueshieldca.com

The hearing impaired may contact the Customer Service Department through the toll-free TTY number, 1-800-241-1823.

Customer Service can answer many questions over the telephone.

CALIFORNIA DEPARTMENT OF INSURANCE REVIEW.

The California Department of Insurance is responsible for regulating health insurance. The Department's Consumer Communications Bureau has a toll-free number (1-800-927-HELP (4357) or TDD 1-800-482-4833) to receive complaints regarding health insurance from either the Insured or his or her provider. If you have a complaint against your insurer, you should contact the insurer first and use their grievance process. If you need the Department's help with a complaint or grievance that has not been satisfactorily resolved by the insurer, you may call the Department's toll-free telephone number 8am – 6pm, Monday - Friday (excluding holidays). You may also submit a complaint in writing to: California Department of Insurance, Consumer Communications Bureau, 300 S. Spring Street, South Tower, Los Angeles, California 90013, or through the website:http://www.insurance.ca.gov

GENERAL PROVISIONS

LIABILITY OF SUBSCRIBER IN THE EVENT OF NON-PAYMENT BY BLUE SHIELD LIFE. In accordance with Blue Shield Life's established policies, and by statute, every contract between Blue Shield Life and its Participating Providers stipulates that the Subscriber shall not be responsible to the Participating Provider for compensation for any services to the extent that they are provided in the Insured's Group Policy. Participating Providers have

agreed to accept the Blue Shield Life's payment as payment-in-full for Covered Services, except for Copayments and amounts in excess of specified Benefit maximums, or as provided under the Exception for Other Coverage and Reductions-Third Party Liability sections.

If services are provided by a Non-Participating Provider, the Insured is responsible for all amounts Blue Shield Life does not pay.

When a Benefit specifies a Benefit maximum and that Benefit maximum has been reached, the Insured is responsible for any charges above the Benefit maximums.

ENTIRE POLICY. The Policy, including appendices, attachments or other documents incorporated by reference forms the entire agreement between Blue Shield Life and the Group Policyholder. Any statement made by the Group Policyholder or any Insured shall, in the absence of fraud, be deemed a representation and not a warranty. Such statements will not be used to deny a claim or void coverage unless contained in a written application.

TIME LIMIT ON CERTAIN DEFENSES. After two consecutive years following issuance of this Policy, Blue Shield Life will not use any omission, misrepresentation or inaccuracy made in the application to limit, cancel or rescind the Policy, deny a claim, or raise premiums.

GRACE PERIOD. After payment of the first premium, the Group Policyholder is entitled to a grace period of 31 Days for the payment of any premiums due. During this grace period, the Policy will remain in force. However, the Group Policyholder will be liable for payment of premiums accruing during the period the Policy continues in force.

PLAN CHANGES. The Benefits and terms of this Plan, including but not limited to, Covered Services, Copayments, and Benefit maximums, are subject to change at any time. Blue Shield Life will provide at least 60 Days' written notice of any such change.

Benefits for services or supplies furnished on or after the effective Date of any change in Benefits will be provided based on the change.

RIGHT OF RECOVERY. Whenever payment on a claim has been made in error, Blue Shield Life will have the right to recover such payment from the Subscriber or Insured or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. Blue Shield Life reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of Benefits in excess of the Benefits provided by the health plan, payment of amounts that are the responsibility of the Subscriber or Insured (Copayments, Benefit maximums or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Subscriber or Insured's eligibility, or payments on fraudulent claims.

NON-ASSIGNABILITY. Coverage or any Benefits of this Plan may not be assigned without the written consent of Blue Shield Life. To be entitled to services, the Insured must be a

Subscriber or Dependent who has been accepted by the Employer and enrolled by Blue Shield Life and who has maintained enrollment under the terms of this Policy.

GRIEVANCE PROCESS

The Insureds, a designated representative, or a provider on behalf of the Insured, may contact the Vision Customer Service Department by telephone, letter, or online to request a review of an initial determination concerning a claim or service. An Insured may contact Vision Customer Service at the telephone number noted above. If the telephone inquiry to Vision Customer Service does not resolve the question or issue to the Insured's satisfaction, the Insured may request a grievance at that time, which the Vision Customer Service Representative will initiate on the Insured's behalf.

The Insured, a designated representative, or a provider on behalf of the Insured, may also initiate a grievance by submitting a letter or a completed grievance form. The Insured may request this form from Vision Customer Service. If the Insured wishes, the Vision Customer Service staff will assist in completing the grievance form. Completed grievance forms must be mailed to a Vision Plan Administrator at the address provided below. The Insured may also submit the grievance to Vision Customer Service online by visiting http://www.blueshieldca.com.

1-877-601-9083
Vision Plan Administrator
P. O. Box 25208
Santa Ana, CA 92799-5208

A Vision Plan Administrator will acknowledge receipt of a written grievance within five (5) calendar Days. Grievances are resolved within 30 Days. The grievance system allows Insureds to file grievances within 180 Days following any incident or action that is the subject of the Insured's dissatisfaction.

EXTERNAL INDEPENDENT MEDICAL REVIEW. If your grievance involves a claim or services for which coverage was denied by Blue Shield Life or by a contracting provider in whole or in part on the grounds that the service is not medically necessary, you may choose to make a request to the Department of Insurance to have the matter submitted to an independent agency for external review in accordance with California law. You normally must first submit a grievance to Blue Shield Life and wait for at least 30 Days before you request external review. You may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Vision Customer Service. The Department of Insurance will review the application and, if the request qualifies for external review, will select an external review agency and have your records submitted to a qualified specialist for an independent determination of whether the care is medically necessary. You may choose to submit additional records to the external review agency for review. There is no cost to you for this external review. You and your physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield Life; if the external reviewer determines that the service is medically necessary, Blue Shield Life will promptly arrange for the service to be provided or the claim in dispute to be paid. This external review process is in addition to any other procedures or remedies available to you and is

completely voluntary on your part; you are not obligated to request external review. However, failure to participate in external review may cause you to give up any statutory right to pursue legal action against Blue Shield Life regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Vision Customer Service.

blue of california

Blue Shield of California Life & Health Insurance Company
Summary of Benefits

Trader Joe's Company
Effective July 1, 2023

Custom Eye Exam Only

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Life & Health Insurance Company (Blue Shield Life) Plan. It is only a summary and it is included as part of the Certificate of Insurance (COI).[1] Please read both documents carefully for details.

Provider Network:

This Plan uses a contracted network of vision care providers. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Benefit Frequency Limits

This Plan pays up to the Allowance and frequency limits as listed for Covered Services.

Comprehensive exam	One every 12 consecutive months
Diabetes management referral	One every Calendar Year

Waiting Period

A waiting period is the length of time you must be covered under the Plan before Blue Shield Life will pay for Covered Services.

Waiting period	No waiting period

No Deductible

Under this Plan there is no dollar amount an Insured must pay before Blue Shield Life will pay for Covered Services.

No Lifetime Dollar Limit

Under this Plan there is no dollar limit on the total amount Blue Shield Life will pay for Covered Services in an Insured's lifetime.

Benefits[2]	Your payment	
	When using a Participating Provider[3]	**When using a Non-Participating Provider[4]**
Eye examinations		
Comprehensive exam *One per Insured every 12 months.*		
Ophthalmologic visit	$20	All charges above $60
Optometric visit	$20	All charges above $50
Retinal Imaging *One per Insured every 12 months by a Participating Provider instead of a standard comprehensive exam with dilation.*	$39	Not covered
Standard contact lens fitting and evaluation *One per Insured every 12 months by a Participating Provider if administered at the same time as the comprehensive exam.*	Not covered	Not covered
Other services		
Low-vision testing and equipment *One per Insured every 12 months by a Participating Provider. Exam must be Medically Necessary, requires a report from the provider and prior authorization from the VPA.*	Not covered	Not covered
Diabetes management referral *One per Insured, per Calendar Year to a Participating Provider when you are known to have or be at risk for diabetes.*	$0	Not covered

Notes

1 Certificate of Insurance (COI):

The Certificate of Insurance (COI) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the COI for more details of coverage outlined in this Summary of Benefits. You can request a copy of the COI at any time.

Capitalized terms are defined in the COI. Refer to the COI for an explanation of the terms used in this Summary of Benefits.

2 Vision Care Services:

All vision Benefits are provided through Blue Shield Life's Vision Plan Administrator (VPA).

3 Using Participating Providers:

Participating Providers have a contract to provide vision care services to Insureds. When you receive Covered Services from a Participating Provider, you are responsible for:

- the Copayment, and
- any charges above the stated Allowance, which is the Benefit maximum.

4 Using Non-Participating Providers:

Notes

Non-Participating Providers do not have a contract to provide vision care services to Insureds. When you receive Covered Services from a Non-Participating Provider, you are responsible for:

- the Copayment, and
- any charges above the stated Allowance, which is the Benefit maximum.

Blue Shield of California Life & Health Insurance Company

Notice Informing Individuals about
Nondiscrimination and Anccessibility Requirements

Discrimination is against the law

Blue Shield of California Life & Health Insurance Company complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California Life & Health Insurance Company does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield Life:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield Life Civil Rights Coordinator.

If you believe that Blue Shield Life has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California Life & Health Insurance Company Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070

Email:BlueShieldCivilRightsCoordinator@blues
hieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You may also contact the California Department of Insurance if you believe that Blue Shield of California Life & Health Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. You can file a grievance with:

California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street, South Tower
Los Angeles, California 90013

Phone: (1-800-927-HELP (4357) or TDD 1-800-482-4833)

Complaint forms are available at
www.insurance.ca.gov/01-consumers/101-help

If you believe that you have not been provided these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201

(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at
www.hhs.gov/ocr/office/file/index.html.

Notice of the Availability of Language Assistance Services

Blue Shield of California Life & Health Insurance Company

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance), по телефону 1-800-927-4357. Russian

無料の言語サービス　日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、ＩＤカード記載の番号または1-866-346-7198までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند.برای دریافت کمک،با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید.برای دریافت کمک بیشتر، به CA Dept. of Insurance(اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید.Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ' ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول علي مترجم و قراءة الوثائق لك باللغة العربية. للحصول علي المساعدة، اتصل بنا علي الرقم المبين علي بطاقة عضويتك أو علي الرقم 1-866-346-7198. للحصول علي المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا علي الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

บริการทางภาษาอย่างไม่เสียค่าใช้จ่าย คุณสามารถรับบริการจากล่าม รวมถึงให้เจ้าหน้าที่อ่านเอกสารให้คุณฟัง หรือส่งเอกสารบางส่วนในภาษาของคุณไปหาคุณได้ หากต้องการความช่วยเหลือ กรุณาโทรศัพท์ตามหมายเลขที่ระบุอยู่ด้านหลังบัตรประจำตัวของคุณ หรือ ที่หมายเลข 1-866-346-7198 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรมาที่ กรมการประกันภัยแห่งมลรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 Thai

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया की सेवा प्राप्त कर सकते हैं। आप दस्तावेजों को पढ़वा के सुन सकते हैं और कुछ को अपनी भाषा में स्वयं को भिजवा सकते हैं। सहायता के लिए, अपने ID कार्ड पर दिए गए नंबर पर, या 1-866-346-7198 पर हमें फ़ोन करें। अधिक सहायता के लिए कैलीफोर्निया बीमा विभाग (CA Dept. of Insurance) को 1-800-927-4357 पर फ़ोन करें। Hindi

Doo bááh ílínígó saad bee yát'i' bee aná'áwo'. Díí shá ata'halne'dooígí hólǫǫdoo nínízingo éí bíighah. Naaltsoos naanin——áhájeehígí shich'į' yíidooltah éí doodagó ła' shich'į' ádoolníił nínízingo bíighah. Shíká a'doowoł nínízingo nihich'į' béésh bee hodíilnih dóó námboo éí díí ninaaltsoos dootł'ízhígí bee néího'dílzinígí bine'dée' bikáá' éí doodagó éí (866)346-7198jį' hodíilnih. Hózhǫ shíká anáá'doowoł nínízingo éí díí béeso ách'ąąh naa'nil bił haz'ą́ąjį' 1-800-927-4357jį' hodíilnih. Navajo

ບໍລິການແປພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍເອົາຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງ ແລະ ສົ່ງເອກະສານບາງຢ່າງທີ່ເປັນພາສາຂອງທ່ານ. ສຳລັບຄວາມຊ່ວຍເຫຼືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມເບີໂທລະສັບທີ່ມີໃນບັດປະຈຳຕົວຂອງທ່ານ ຫຼື ໂທຫາເບີ1-866-346-7198. ສຳລັບຄວາມຊ່ວຍເຫຼືອເພີ່ມເຕີມໂທຫາ ພະແນກ ປະກັນໄພ ຂອງລັດຄາລິຟໍເນຍໄດ້ທີ່ເບີ1-800-927-4357. Laotian