UnitedHealthcare Vision

UnitedHealthcare Insurance Company

Certificate of Coverage

For

the Plan: VH652

of

City of Burleson

Group Number: 906435

Effective Date: January 1, 2025

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call UnitedHealthcare Insurance Company's toll-free telephone number for information or to make a complaint at:

1-888-321-0881

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P. O. Box 149104

Austin, TX 78714-9104

FAX:(512) 490-1007

Web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de UnitedHealthcare Insurance Company's para obtener información o para presentar una queja al:

1-888-321-0881

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P. O. Box 149104

Austin, TX 78714-9104

FAX:(512) 490-1007

Sitio web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

Certificate of Coverage

UnitedHealthcare Insurance Company

What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Group. The *Certificate* describes Covered Vision Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's *Application* and payment of the required Policy Charges.

In addition to this *Certificate,* the Policy includes:

- The *Schedule of Covered Vision Care Services*.
- The Group's *Application*.
- Riders.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When this happens we will send you a new *Certificate*, Rider or Amendment.

Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

We are delivering the Policy in Texas. The Policy is governed by ERISA unless the Group is not an employee health and welfare plan as defined by ERISA. To the extent that state law applies, Texas law governs the Policy.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

How Do You Use This Document?

Read your entire *Certificate* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Certificate* and *Schedule of Covered Vision Care Services* and any attachments in a safe place for your future reference.

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Covered Vision Care Services* along with *Section 1: Covered Vision Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this *Certificate* and any summaries provided to you by the Group, this *Certificate* controls.

Please be aware that your Vision Provider is not responsible for knowing or communicating your Benefits.

How Do You Contact Us?

Call us at 1-800-638-3120. Throughout the document you will find statements that encourage you to contact us for more information.

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Policy issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. If you have questions about this, contact your Group.

Be Aware the Policy Does Not Pay for All Vision Care Services

The Policy does not pay for all vision care services. Benefits are limited to Covered Vision Care Services. The *Schedule of Covered Vision Care Services* will tell you the portion you must pay for Covered Vision Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Vision Provider. We do not make decisions about the kind of care you should or should not receive.

Choose Your Vision Provider

It is your responsibility to select the vision care professionals who will deliver your care. We arrange for Vision Providers and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners that are solely responsible for the care they deliver.

Pay Your Share

You must meet any applicable Deductible and pay a Co-payment and/or Co-insurance for most Covered Vision Care Services. These payments are due at the time of service or when billed by the Vision Provider. Any applicable Deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Covered Vision Care Services*. You must also pay any amount that exceeds your Benefits.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions.

File Claims with Complete and Accurate Information

When you receive Covered Vision Care Services from an out-of-Network Vision Provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether the Policy will pay for any portion of the cost of a vision care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive.

We have the authority to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Covered Vision Care Services* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may assign this authority to other persons or entities that may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Vision Care Services

We pay Benefits for Covered Vision Care Services as described in *Section 1: Covered Vision Care Services* and in the *Schedule of Vision Care Services*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Vision Care Services. It also means that not all of the vision care services you receive may be paid for (in full or in part) by the Policy.

Pay Network Providers

It is the responsibility of Network Vision Providers and facilities to file for payment from us. When you receive Covered Vision Care Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Vision Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, we pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*. Your cost sharing may be more when you see an out-of-Network Vision Provider.

Certificate of Coverage Table of Contents

Section 1: Covered Vision Care Services

When Are Benefits Available for Covered Vision Care Services?

Benefits are available only when all of the following are true:

- The vision care service, including materials as shown in the *Schedule of Covered Vision Care Services*.
- You receive Covered Vision Care Services while the Policy is in effect.
- You receive Covered Vision Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Vision Care Services is a Covered Person and meets all eligibility requirements specified in the Policy.

This section describes Covered Vision Care Services for which Benefits are available. Please refer to the attached *Schedule of Covered Vision Care Services* for details about:

The amount you must pay for these Covered Vision Care Services (including any Co-payment).

- Any limit that applies to these Covered Vision Care Services (including frequency and dollar limits on services and materials).

1. Routine Vision Examination

A routine vision exam of the eyes and according to the standards of care in your area, including:

A. A patient history that includes reasons for the exam, patient medical/eye history, and current medications;

B. Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40);

C. Cover test at 20 feet and 16 inches (checks how the eyes work together as a team);

D. Ocular motility (how the eyes move) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D Vision);

E. Pupil reaction to light and focusing;

F. Exam of the eye lids, lashes, and outside of the eye;

G. Refraction (when applicable) - to determine power of corrective lenses for distance and near vision; Retinoscopy (when applicable): Objective refraction to determine lens power of corrective lenses. Subjective refraction to determine lens power of corrective lenses;

H. Photometry/Binocular testing - far and near: how well eyes work as a team;

I. Tonometry, when indicated: test pressure in eye (glaucoma check);

J. Ophthalmoscopic exam of the internal eye;

K. Visual field testing;

L. Biomicroscopy;

M. Color vision testing;

N. Diagnosis/prognosis;

O. Dilation (when indicated) - Examine the internal structures of the eye; and

P. Specific recommendations.

Post exam procedures will be performed only when materials are required.

Or in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

2. Retinal Photography

Film or digital pictures taken of the back of your eye, which includes the retina and optic nerve.

3. Eyeglass Lenses

Lenses that are mounted in an eyeglass frame and worn on the face to correct visual acuity limitations.

4. Eyeglass Frame

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

5. Optional Lens Extras

Special lens stock or modifications to lenses that do not correct visual acuity problems. Optional Lens Extras include options such as, but not limited to, lens tints, polycarbonate lenses, high-index lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photochromic.

6. Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

7. Necessary Contact Lenses

This benefit is available where a Vision Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Provider and not by us.

Contact lenses are necessary if the Covered Person has:

A. Keratoconus;

B. Anisometropia;

C. Irregular corneal/astigmatism;

D. Aphakia;

E. Facial deformity;

F. Corneal deformity;

G. Pathological myopia;

H. Aniseikonia;

I. Aniridia;

J. Post-traumatic disorders;

K. Post-cataract surgery without intraocular lens; or

L. Visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses.

8. Contact Lens Fitting & Evaluation

A contact lens evaluation and fitting includes examination and measurement of the eyes and adjacent structures to determine the contact lens size, design and power to achieve and maintain eye health, comfort and vision.

9. Virtual Visits

Virtual visits for Covered Vision Care Services through live audio and video technology. Virtual visits provide a Routine Vision Examination for the patient by a distant Vision Provider.

Network Benefits are available only when services are delivered through a Designated Virtual Network Vision Provider. You can find a Designated Virtual Network Vision Provider by contacting us at www.myuhcvision.com or by calling us at 1-800-638-3120.

Please Note: Not all Routine Examinations or other services can be provided through virtual visits. The Designated Virtual Network Vision Provider will identify any patients for which services by in-person Vision Provider is needed.

Benefits do not include email or fax.

Section 2: Exclusions and Limitations

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, and materials described in this section, even if it is recommended or prescribed by a Physician or Vision Provider.

The services, treatments, and materials listed in this section are not Covered Vision Care Services, except as may be specifically provided for in *Section 1: Covered Vision Care Services* or through a Rider to the Policy.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Vision Care Service categories described in *Section 1: Covered Vision Care Services*, those limits are stated in the corresponding Covered Vision Care Service category in the *Schedule of Covered Vision Care Services*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

The following Services and materials are excluded from coverage under the Policy:

A. Non-prescription items (e.g. Plano lenses) other than those listed in the *Schedule(s) of Covered Vision Care Services*.

B. Services that the Covered Person, without cost, obtains from any governmental organization or program.

C. Services for which the Covered Person may be compensated under Workers' Compensation Law, or other similar employer liability law.

D. Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.

E. Medical or surgical treatment for eye disease, which requires the services of a Physician.

F. Replacement or repair of lenses and/or frame that have been lost or broken.

G. Optional Lens Extras not listed in the *Schedule of Covered Vision Care Services*.

H. Technological devices such as smart phones and tablets used as Optical Low Vision Aids.

I. Missed appointment charges.

J. Applicable sales tax charged on Services.

K. Services that are not specifically covered by the Policy.

L. Procedures that are considered to be Experimental, Investigational or Unproven. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

M. Any Vision Service Covered under an Essential Health Benefit plan is not Covered under this Policy.

N. Any Vision Service rendered by the Policyholder.

O. Intraocular lenses.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Group. The Group will submit the completed forms to us, along with any required Premium. We will not provide Benefits for vision care services that you receive before your effective date of coverage.

Who Is Eligible for Coverage?

The Group determines who is eligible to enroll and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 9: Defined Terms*.

Eligible Persons must live within the United States.

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- The Subscriber is a party in a suit seeking adoption.
- The date the adoption becomes final.
- Marriage.
- Legal guardianship.
- Court or administrative order.

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event.

Coverage for a new Dependent child by birth or adoption begins on the date of the event and remains in effect for 31 days. To continue coverage beyond the initial 31 day period, the Subscriber must notify us of the event and pay any required Premium within 31 days of the event. If no additional monthly premium will be required, a newborn child will be covered from the moment of birth.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- The Subscriber is a party in a suit seeking adoption.
- The date the adoption becomes final.
- Marriage.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health*

Insurance Program (CHIP). Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.

- The Eligible Person and/or Dependent had existing vision coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including legal separation, divorce or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
  - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Your right to Benefits automatically ends on the date that coverage ends. When your coverage ends, we will still pay claims for Covered Vision Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any vision care services received after that date.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends on the date we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later.

- **Subscriber Retires or Is Pensioned**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the date the Subscriber is retired or receiving benefits under the Group's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's *Application*, and only if the Subscriber continues to meet any applicable eligibility requirements. The Group can provide you with specific information about what coverage is available for retirees.

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 15 days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

If Covered Vision Care Services are in progress on the date which coverage terminated, such Services will be completed, except where termination is due to fraud, misrepresentation, material violation of the terms of the Policy, or failure to pay required Premiums.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental or physical handicap or disability.
- The Enrolled Dependent child depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Policy.

You must furnish us with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician we choose examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at our expense. We will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Continuation of Coverage

If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Section 5: How to File a Claim

How Are Covered Vision Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Vision Care Services. If a Network provider bills you for any Covered Vision Care Service, contact us. However, you are required to meet any applicable Deductible and to pay any required Co-payments and/or Co-insurance to a Network provider. You will also be responsible for any charges that are not Covered by the Policy to your Vision Provider.

How Are Covered Vision Care Services from an Out-of-Network Provider Paid?

When you receive Covered Vision Care Services from an out-of-Network provider you will be required to pay all billed charges to your Vision Provider. You are also responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that vision care service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- Your identification number.
- The name and address of the provider of the service(s).
- An itemized bill from your provider that includes a description of each charge.

The above information should be filed with us at Claims Department, P.O. Box 30978, Salt Lake City, UT 84130 or by fax to 248-733-6060. If you would like to use a claim form, you may access a form on the Internet at www.myuhcvision.com or call us at 1-800-638-3120 and a claim form will be provided to you. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above.

Payment of Benefits

You may not assign your Benefits under the Policy or any cause of action related to your Benefits under the Policy to an out-of-Network Vision Provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to the Subscriber for reimbursement to an out-of-Network provider. We may, as we determine, pay an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network Vision Provider, we have the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to an out-of-Network Vision Provider with our consent, and the out-of-Network Vision Provider submits a claim for payment, you and the out-of-Network Vision Provider represent and warrant the following:

- The Covered Vision Care Services were actually provided.
- The Covered Vision Care Services were appropriate.

Payment of Benefits under the Policy shall be in cash or cash equivalents, or in a form of other consideration that we determine to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes us, or to other plans for which we make payments where we have taken an assignment of the other plans' recovery rights for value.

If the Covered Vision Care Services you received are covered by the Texas Department of Human Services ("DHS"), we will reimburse DHS.

If there is a court order providing for the managing conservator of a minor child, we will reimburse the conservator on your behalf.

Obtaining Services

To find a Network Vision Provider, you may access a listing of Network Vision Providers on the Internet at www.myuhcvision.com. You may also call the UnitedHealthcare Provider Locator Service at 1-800-839-3242.

You also may obtain Vision Care Services from an out-of-Network Vision Provider. However, the amount of Benefits may be reduced.

Foreign Services

Foreign Services will be treated as Out-of-Network Benefits under this Policy. Payments will be made in U.S. currency and dispersed to the U.S. address of the Subscriber. We make no guarantee on value of payment and will not protect against currency risk. Currency valuations for payment liability will be based on exchange rates published on the date the Vision Care Services were rendered.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Contact Customer Service at 1-800-638-3120. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Contact Customer Service at 1-800-638-3120. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How Do You Appeal a Claim Decision?

How to Request an Appeal

If you disagree with either claim determination or a rescission of coverage determination, you can contact us in writing or orally to request an appeal.

Your request for an appeal should include:

- The patient's name and Policy number.
- The date(s) of vision service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to us within 180 days after you receive claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a vision care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask vision experts to take part in the appeal process. You consent to this referral and the sharing of needed vision claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of Benefits, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is specific to Texas law regarding coordination of benefits.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan**. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan**. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

Definitions

For purposes of this section, terms are defined as follows:

A. **Plan**. A Plan is any of the following that provides benefits or services for medical, pharmacy or vision care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of vision care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

2. Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or

other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as vision benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. **Order of Benefit Determination Rules**. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits equal100% of the total Allowable Expense.

D. **Allowable Expense.** Allowable Expense is a health care expense, including deductibles, co-insurance and co-payments, 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. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private 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 methodology or other similar reimbursement methodology, 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. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

E. **Allowed Amount.** Allowed Amount is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or physician. The allowed

amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible..

F. **Closed Panel Plan.** Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

G. **Custodial Parent.** Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

What Are the Rules for Determining the Order of Benefit Payments?

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

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

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 provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan where a covered person uses a noncontracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.

E. When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

F. If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.

G. Each 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, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the 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 (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee,

member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

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 covered the parent longest is the Primary Plan.

For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court order 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 plan years commencing after the plan is given notice of the court decree.

(2) If a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court order allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the Custodial Parent.

(b) The Plan covering the Custodial Parent's spouse.

(c) The Plan covering the non-Custodial Parent.

(d) The Plan covering the non-Custodial Parent's spouse.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

(i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

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 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 not apply if the rule labeled D.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to 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 labeled D.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time 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 shall 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.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the 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 equaling 100 percent of the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Compliance With Federal and State Laws Concerning Confidential Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Each person claiming benefits under this plan must give us any facts we need to apply those rules and determine benefits.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the 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.

Does This Plan Have the Right of Recovery?

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any

other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

How Are Benefits Paid When This Plan is Secondary to Medicare?

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits.

Section 8: General Legal Provisions

What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We do not provide vision services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's Policy will cover or pay for the vision care that you may receive. The Policy pays for Covered Vision Care Services, which are more fully described in this *Certificate*.
- The Policy may not pay for all vision services or materials you or your Vision Provider may believe are needed. If the Policy does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

What Is Our Relationship with Providers and Groups?

The relationships between us and Network Vision Providers and Groups are solely contractual relationships between independent contractors. Network Vision Providers and Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network Vision Providers or the Groups.

We do not provide vision care services or materials. We arrange for vision providers to participate in a Network and we pay Benefits. Network Vision Providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network vision providers such as principal-agent or joint venture. We are not responsible for any act or omission of any vision provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Policy. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Policy.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of when the Policy ends.

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

What Is Your Relationship with Providers and Groups?

The relationship between you and any vision provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own Vision Provider.
- Paying, directly to your Vision Provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any Deductible and any amount that exceeds your Benefits.
- Paying, directly to your Vision Provider, the cost of any non-Covered Vision Care Service.
- Deciding if any Vision Provider treating you is right for you. This includes Network Vision Providers you choose and vision providers that they refer.
- Deciding with your Vision Provider what care you should receive.
- Paying all billed charges, directly to your out-of-Network provider.

Your Vision Provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

How Do We Use Headings?

The headings, titles and any table of contents contained in the Policy, *Certificate* or *Schedule of Covered Vision Care Services* are for reference purposes only and shall not in any way affect the meaning or interpretation of the Policy, *Certificate* or *Schedule of Covered Vision Care Services*.

Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy after it has been in force for two years unless it is a fraudulent statement.

Are Incentives Available to You?

Sometimes we may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, we recommend that you discuss taking part in such programs with your Vision Provider. Contact us at www.myuhcvision.com or contact us at 1-800-638-3120 if you have any questions.

Who Interprets Benefits and Other Provisions under the Policy?

We have the authority to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Covered Vision Care Services* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Vision Care Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning vision care services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for review or quality assessment.

- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your vision records or billing statements you may contact your Vision Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request vision forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Vision Provider of our choice examine you at our expense.

Is Workers' Compensation Affected?

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Subrogation and Reimbursement

Subrogation applies when we have paid Benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits we have paid that are related to the Sickness and Injury for which a third party is considered responsible.

Reimbursement is the payment by you out of the recovery received from any third party to us to be limited to the amount of medical benefits paid by us. We may request and receive reimbursement of any type of recovery for the reasonable value of any services and Benefits we provided to you subject to Section140.005 of the Civil Practice and Remedies Code. We may receive reimbursement for the total amount of past Benefits paid, not to exceed the amount you receive from any third party as described below

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators. We may pursue recovery against an underinsured or uninsured motorist for medical payments coverage if the Covered Person or their immediate family did not pay the premiums for the coverage.

- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a sickness or injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

  Your failure to cooperate with us is considered a breach of contract. As such, we have the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by us due to you or your representative not cooperating with us. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- We have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- Our subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your Estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. We are not required to help you to pursue your claim for damages or personal injuries.
- Regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which we may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.
- Benefits paid by us may also be considered to be Benefits advanced.

- If you receive any payment from any party as a result of sickness or injury, and we allege some or all of those funds are due and owed to us, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Policy, you agree that (i) any amounts recovered by you from any third party shall constitute Policy assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Policy (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by us to enforce its reimbursement rights.
- Our right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from us, you agree to assign to us any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits we have paid for the sickness or injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize our right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- We may, at our option, take necessary and appropriate action to preserve our rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the sickness or injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in your name or your Estate's name, which does not obligate us in any way to pay you part of any recovery we might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Policy is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse us, without our written approval.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death our right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse us is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interest unless we provide written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or injury caused by any third party. If a parent or guardian brings a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under the Policy, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Policy pertaining to reimbursement, we may terminate Benefits to you, your dependents or the subscriber, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits we have paid relating to any sickness or injury alleged to have been caused or caused by any third party to the

extent not recovered by us due to your failure to abide by the terms of the Policy. If we incur attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.

- We and all Administrators administering the terms and conditions of the Policy's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions to (1) construe and enforce the terms of the Policy's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to us.

When Do We Receive Refunds of Overpayments?

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Policy. If the refund is due from a person or organization other than you, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Is There a Limitation of Action?

Prior to bringing any legal action against us to recover reimbursement we recommend that you have completed all the steps in the appeal process described in Section 6: Questions, Complaints and Appeals. After completing that process, if you want to bring a legal action against us you must do so after the 61st day written proof of loss is filed or within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Covered Vision Care Services*, the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group.

Section 9: Defined Terms

Amendment - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Benefits - your right to payment for Covered Vision Care Services that are available under the Policy.

Co-insurance - the charge, stated as a percentage, that you are required to pay for certain Covered Vision Care Services.

Co-payment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Vision Care Services.

Covered Contact Lens Formulary - a selection of available contact lenses that may be obtained from a Network Vision Provider on a covered-in-full basis, subject to payment of any applicable Co-payment.

Covered Person - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Certificate* to refer to a Covered Person.

Covered Vision Care Service(s) - vision care services which we determine to be all of the following:

- Necessary.
- Described as a Covered Vision Care Service in this *Certificate* under *Section 1: Covered Vision Care Services* and in the *Schedule of Covered Vision Care Services*.
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Dependent - the Subscriber's legal spouse or an unmarried child of the Subscriber or the Subscriber's spouse. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse or a child who is the subject of a suit in which the Subscriber or the Subscriber's spouse seeks to adopt the child.
- The term child also includes a grandchild of either the Subscriber or the Subscriber's spouse.
- A child for whom vision care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A Dependent includes an unmarried child age 26 or older who is or becomes disabled and dependent upon the Subscriber.
- A Dependent includes a grandchild of the Subscriber, who is unmarried, under 25 years of age and is a Dependent of the Subscriber for federal income tax purposes at the time the application for coverage of the grandchild is made.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month following the date the child reaches age 26.

The Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Vision Care Services through live audio and video technology.

Eligible Person - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Policy. An Eligible Person must live within the United States.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Not demonstrated through prevailing peer-related professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Foreign Services-services provided outside the U.S. and U.S. territories.

Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Network - when used to describe a provider of vision care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Vision Care Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Vision Care Services, but not all Covered Vision Care Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Vision Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Vision Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Vision Care Services provided by Network Vision Providers. The *Schedule of Covered Vision Care Services* will tell you if your plan offers Network Benefits and how Network Benefits apply.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Vision Care Services provided by out-of-Network Vision Providers. The *Schedule of Covered Vision Care Services* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Open Enrollment Period - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy. The Group sets the period of time that is the Open Enrollment Period.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Group that includes all of the following:

- *Group Policy*.
- *Certificate*.
- *Schedule of Covered Vision Care Services*.
- Group *Application*.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Group.

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Rider - any attached written description of additional Covered Vision Care Services not described in this *Certificate*. Covered Vision Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

Telehealth Service - a vision service, other than a Telemedicine Medical Service, delivered by a Vision Provider licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the Vision Provider's license, certification, or entitlement to a patient at a different physical location than the Vision Provider using telecommunications or information technology.

Telemedicine Medical Service - a Vision Care Service delivered by a Physician licensed in this state, or Vision Provider acting within the scope of their license to a patient at a different physical location than the Physician or Vision Provider using telecommunications or information technology.

Vision Provider - any optometrist, ophthalmologist, therapeutic optometrist, surgeon, or other person who may lawfully provide services to Covered Persons participating in our vision plans.

Schedule of Covered Vision Care Services

The following Vision Care Services will be covered, subject to a Co-payment, when obtained from Network Providers.

When obtaining these Vision Care Services from a Network Provider, you will be required to pay a Co-payment at the time of service for certain Vision Care Services. The amount of Co-payment that a Network Provider will charge is as noted in the column "Network Benefit" in the chart below.

When obtaining these Vision Care Services from an out-of-Network Provider, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement for out-of-Network Providers will be limited to the amounts noted in the column "out-of-Network Benefit" in the chart below.

The out-of-Network Co-insurance Benefits will not be more than 50% of the total covered portion of the Service.

When Covered Vision Care Services are rendered to a Covered Person by an out-of-Network Vision Provider because there was not a Network Vision Provider reasonably available, we will:

- Pay the claim, at a minimum, at the usual, reasonable or customary changes for the Covered Vision Care Service, less any applicable Co-Insurance or Co-Payment amount;
- Pay the claim at the Network Benefit Co-Insurance level; and
- In addition, to any amount that would have been credited had the provider been a Network Vision Provider, credit any out-of-pocket amounts you paid to the out-of-Network provider for charges for Covered Vision Care Services that were above and beyond the Benefit amount towards the Deductible and out-of-pocket limit applicable to Network Services.

SERVICE[M,K]	**FREQUENCY OF SERVICE**	**NETWORK BENEFIT** **The Amount You Pay**	**OUT-OF-NETWORK BENEFIT**
Routine Vision Examination for Dependent children up to age 13	Twice every 12 months[A]	Co-payment of $10.	To a maximum of a $40 allowance.
Routine Vision Examination for Covered Persons age 13 or older	Once every 12 months	Co-payment of $10.	To a maximum of a $40 allowance.
Routine Vision Examination for diabetics	Once every 12 months	Co-payment of $10.	To a maximum of a $40 allowance.
Routine Vision Examination for the following conditions: pregnancy or breastfeeding	Once every 12 months[A]	Co-payment of $10.	To a maximum of a $40 allowance.
Refraction Only in lieu of Routine Vision Examination for Dependent children up to age 13	Twice every 12 months[A]	To a maximum of a $0 allowance.	To a maximum of a $40 allowance.

SERVICE[M,K]	**FREQUENCY OF SERVICE**	**NETWORK BENEFIT** **The Amount You Pay**	**OUT-OF-NETWORK BENEFIT**
Refraction Only in lieu of Routine Vision Examination for Covered Persons age 13 or older	Once every 12 months	To a maximum of a $0 allowance.	To a maximum of a $40 allowance.
Retinal Photography for diabetics	Once every 12 months	Co-payment of $0.	To a maximum of a $0 allowance.
EYEGLASS FRAME[B1, G]	Once every 12 months		
Eyeglass Frame		Co-payment of $25[C] to a maximum of a $150 allowance.	To a maximum of a $45 allowance.
EYEGLASS LENSES[B1]	Once every 12 months		
Single Vision Lenses*		Co-payment of $25[C].	To a maximum of a $40 allowance.
Bifocal-lined Lenses		Co-payment of $25[C].	To a maximum of a $60 allowance.
Trifocal-lined Lenses		Co-payment of $25[C].	To a maximum of a $80 allowance.
Lenticular Lenses		Co-payment of $25[C].	To a maximum of a $80 allowance.
OPTIONAL LENS EXTRAS[F]	Once every 12 months		
Standard Scratch Coating		Co-payment of $0.	To a maximum of a $0 allowance.
Oversize Lenses		50% of retail billed charge after a Co-payment of $25.	To a maximum of a $0 allowance.
Blended Bifocal Lenses		50% of retail billed charge after a Co-payment of $25[C] toward Covered Eyeglass Lenses.	To a maximum of a $0 allowance.
Tier One Progressive Lenses		After a Co-payment of $25[C] toward Covered Eyeglass Lenses and the lesser of $55 or retail billed charge.	To a maximum of a $0 allowance.
Tier Two Progressive Lenses		After a Co-payment of $25[C] toward Covered Eyeglass Lenses and	To a maximum of a $0 allowance.

SERVICE[M,K]	FREQUENCY OF SERVICE	NETWORK BENEFIT The Amount You Pay	OUT-OF-NETWORK BENEFIT
		the lesser of $100 or retail billed charge.	
Tier Three Progressive Lenses		After a Co-payment of $25[C] toward Covered Eyeglass Lenses and the lesser of $150 or retail billed charge.	To a maximum of a $0 allowance.
Tier Four Progressive Lenses		After a Co-payment of $25[C] toward Covered Eyeglass Lenses and the lesser of $200 or retail billed charge.	To a maximum of a $0 allowance.
Tier Five Progressive Lenses		After a Co-payment of $25[C] toward Covered Eyeglass Lenses and the lesser of $250 or retail billed charge.	To a maximum of a $0 allowance.
Aspheric Lenses		50% of retail billed charge after a Co-payment of $25[C] toward Covered Eyeglass Lenses.	To a maximum of a $0 allowance.
Digital Single Vision Lenses		50% of retail billed charge after a Co-payment of $25[C] toward Covered Eyeglass Lenses.	To a maximum of a $0 allowance.
Polycarbonate for Dependent children up to age 19		Co-payment of $0.	To a maximum of a $0 allowance.
Cataract Lenses		50% of retail billed charge after a Co-payment of $25[C] toward Covered Eyeglass Lenses.	To a maximum of a $0 allowance.
Occupational Double Segment Lenses		50% of retail billed charge after a Co-payment of $25[C] toward Covered Eyeglass Lenses.	To a maximum of a $0 allowance.
CONTACT LENSES[B1]	Once every 12 months		
Contact Lenses Formulary[J]		Co-payment of $25. For up to 6 boxes from the Covered Contact Lens	To a maximum of a $150 allowance.

SERVICE[M,K]	FREQUENCY OF SERVICE	NETWORK BENEFIT The Amount You Pay	OUT-OF-NETWORK BENEFIT
		Formulary[D]. One Co-payment for Contact Lens fitting and Evaluation and Contact Lenses Combined if from the Covered Contact Lens Formulary. To a maximum of a $150 allowance for Contact Lenses that are not on the Formulary[D].	
Necessary Contact Lenses[H]		Co-payment of $25.	To a maximum of a $210 allowance.

[A1]The Frequency of Service will be increased for Vision Care Services where the following occurs: Replacement of Lenses and or Frame due to a .50 diopter or more change in prescription.

[B1]You are eligible to select only one of either eyeglasses (Eyeglass Lenses/or Eyeglass Lenses and Eyeglass Frame) or Contact Lenses. If you select more than one of these Vision Care Services, only one service will be covered. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses.

[C]If you purchase Eyeglass Lenses and Eyeglass Frames at the same time from the same Network Provider, only one Co-payment will apply to those Eyeglass Lenses and Eyeglass Frames together.

[D]Coverage for Covered Contact Lens Formulary will not apply at Walmart, Sam's Club, and Costco locations. Other Network locations may not offer Formulary contact lenses. In those cases, your allowance for Contact Lenses that are not on the Formulary will apply.

[F]Coverage for some Optional Lens Extras, which may include progressive lenses, may be included with eyeglass packages offered at some Network locations.

[G]Some eyeglass frame brands may not be available for purchase as a Covered Vision Service, or may be subject to additional limitations.

[H]Necessary contact lenses are in lieu of Contact Lenses.

[J]If Contact Lenses that are not on the Formulary are prescribed; the member will be responsible for the Contact Lens Fitting and Evaluation.

[K]If you choose to use a promotional offer from a provider your claim may be reimbursed based on the out-of-Network coverage.

[M]Additional detail on your plan can be directed to Customer Service 800-638-3120.

[O]The Benefit for an Out-of-Network Routine Vision Examination and Refraction Only Services will be a combined maximum of $40 allowance.

*Single vision lens are defined as one single power across their entire surface with a single optical center and made from CR-39.

All Vision Care Services and procedures follow the criteria specified in the Current Procedural Terminology (CPT) listing as defined by the American Medical Association.

IMPORTANT NOTICE

WHAT TO KNOW ABOUT COORDINATION OF BENEFITS (COB)

Notice: This document is only a summary and does not cover every circumstance. Your benefits will be based on the official terms in your insurance contract. If you have questions, call your health plan at company phone # or the Texas Department of Insurance (TDI) Help Line at 800-638-3120.

It's common for families to have more than one health care plan. For example, this can happen if two parents both work and have family coverage through both employers.

When you have more than one health plan, state law allows your plan to follow a rule— called "coordination of benefits"—to decide how much each plan will pay when you have a claim. The goal is to make sure the two plans don't pay more than the total cost of the health care.

How do I know which plan will pay?

We will ask you what other health plans you and your family have. This will help us know if we are the "primary" or "secondary" payer. The primary plan always pays first when you have a claim. Any plan that doesn't have Texas COB rules will be primary, unless both plans say that the plan with Texas COB rules is primary.

- This health plan will be the primary plan if:
- The claim is for your own health care expenses. There is an exception if you have Medicare and you and your spouse are retired.
- The claim is for your spouse who has Medicare and you aren't both retired.
    - The claim is for your child who is covered by this plan and any of these are true:
    - You're married and your birthday is earlier in the year than your spouse's.
    - You're living with another person (whether or not you've ever been married to that person) and your birthday is earlier than that other person's birthday. This is called the "birthday rule."
    - You're separated or divorced and you told us about a court order that makes you responsible for your child's health care expenses.
    - You don't have a court order, but you have custody of your child.

We will also be primary when state or federal law require us to be. We will be secondary when the rules don't require us to be primary.

How do we pay if we're the primary plan?

When we're the primary plan, we'll pay your health care, just as if you didn't have another plan.

How do we pay if we're the secondary plan?

When we're the secondary plan, we don't pay until the primary plan has paid. We will then pay some or all of the allowable expenses that are left. An "allowable expense" is a health care expense that's covered by your health plan.

Cost differences

If there's a cost difference between what the plans can pay, we will usually base our payment on the higher amount. If one plan has a contract with the doctor or facility and the other doesn't, our combined payments won't be more than the contracted amount. HMOs and PPOs usually have contracts with the providers in their networks.

We might lower our payment to be sure that the amount both plans pay toward your claim combine to equal the total cost. We will credit you any amount we would have paid if you didn't have another plan toward our plan's deductible.

We won't pay any health care expenses that your primary plan didn't cover because you didn't follow its rules and procedures. For example, say your plan paid a lower amount because you didn't get a prior authorization for your health care like the plan requires. We won't pay the amount of the reduction because it isn't an allowable expense.

Language Assistance Services

ATTENTION: If you speak English, free language assistance services and free communications in other formats, such as large print, are available to you. Call 1-800-638-3120. (TTY: 711).

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-800-638-3120.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：1-800-638-3120。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-800-638-3120.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-638-3120 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-800-638-3120.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является Русский (Russian). Позвоните по номеру 1-800-638-3120.

تنبيه: إذا كنت تتحدث العربية (Arabic، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-800-638-3120.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-800-638-3120.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-800-638-3120.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-800-638-3120.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para 1-800-638-3120.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-800-638-3120.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-800-638-3120 an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。1-800-638-3120 にお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. تماس بگیرید. 1-800-638-3120

कृपा ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-800-638-3120

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-800-638-3120.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ(Khmer)សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-800-638-3120 ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-800-638-3120.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-800-638-3120 hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-800-638-3120.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά (Greek), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε 1-800-638-3120.

ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા
વિના મૂલ્યે પ્રાપ્ય છે.
ફુપા કરી 1-800-638-3120 પર કોલ કરો. TTY 711

УВАГА: Якщо ви розмовляєте українською мовою (Ukrainian), у вас є можливість скористатися безкоштовними послугами перекладача. Зателефонуйте, будь ласка, за номером 1-800-638-3120.

AADACHT: Wann du Deitsch Schwetze (Pennsylvanian Dutch) kann, kannscht du frei Schprooch aushilfe griege. Ruf Nummer 1-800-638-3120.

FAAALIGA: Afai e te tautala Faa-Samoa (Samoan), o loo avanoa tautua mo fesoasoani tau gagana mo oe, e le totogia. Faamolemole telefoni le 1-800-638-3120.

Notice of Non-Discrimination

We[1] comply with applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race color, national origin, age, disability or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, please call 1-800-638-3120 or the toll-free member phone number on your member ID card, TTY/RTT 711.

If you believe that we failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can send a complaint to the Civil Rights Coordinator:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

If you need help filing a complaint, please call 1-800-638-3120 or the toll-free member phone number listed on your vision member ID card, TTY/RTT 711.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

This notice is available at: https://www.uhc.com/legal/nondiscrimination-and-language-assistance-notices

[1]For purposes of this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

How to Request an Appeal

If you disagree with a claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and Policy number.
- The date(s) of Vision Service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a Vision care professional with experience in the field, who was not involved in the prior determination. We may consult with, or ask vision experts to take part in the appeal process. You consent to this referral and the sharing of needed vision claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of Benefits, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

VISION PLAN NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2025:

We[1] are required by law to protect the privacy of your health information. We are also required to provide you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice that is currently in effect.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular vision plan, we will post the revised notice on your vision plan website. We have the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice.
- To the *Secretary of the Department of Health and Human Services*, if necessary, to confirm we are meeting our privacy obligations.

We may collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may collect, use, and disclose your health information:

- **For Payment** of premiums owed to us, to determine your vision care coverage, and to process claims for health care services you receive, including for coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage for certain vision procedures and what percentage of the bill may be covered.
- **For Treatment**, including to aid in your treatment or the coordination of your care. For example, we may share information with other doctors to help them provide medical care to you.
- **For Health Care Operations**, as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws.

- **To Provide You Information on Health-Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors**, if your coverage is through an employer sponsored group health plan. We may share summary health information and enrollment and disenrollment information with the plan sponsor. We also may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes**; however, we will not use or disclose your genetic information for such purposes. For example, we may use some health information in risk rating and pricing such as age and gender, as permitted by state and federal regulations. However, we do not use race, ethnicity, language, gender identity, or sexual orientation information in our underwriting process, or for denial of services, coverage, and benefits.
- **For Reminders**, we may collect, use, and disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You** about treatment, payment or health care operations using telephone numbers or email addresses you provide to us.
- **We may** collect, use, and disclose your health information for the following purposes under limited circumstances and subject to certain requirements:
- **As Required by Law** to follow the laws that apply to us.
- **To Persons Involved with Your Care** or who help pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interest. Special rules apply regarding when we may disclose health information about a deceased individual to family members and others. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority. We may also disclose your information to the Food and Drug Administration (FDA) or persons under the jurisdiction of the FDA for purposes related to safety or quality issues, adverse events or to facilitate drug recalls.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements, or for certain activities related to preparing a research study.
- **To Provide Information Regarding Decedents** to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also use and disclose information to funeral directors as needed to carry out their duties.
- **For Organ Donation Purposes** to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is needed for such functions or services. Our business associates are required, under contract with us and according to federal law, to protect the privacy of your information.
- **Additional Restrictions on Use and Disclosure**. Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain sensitive health information. Such laws may protect the following types of information:

    1. Alcohol and Substance Use Disorder
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors' Information
    9. Prescriptions
    10. Reproductive or Sexual Health
    11. Sexually Transmitted Diseases

We will follow the more stringent and protective law, where it applies to us.

Except for uses and disclosures described in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain marketing communications, without your written authorization. Once you give us authorization to use or disclose your health information, you may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. For information on how to revoke your authorization, call the phone number listed on your vision plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** our uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures of your information to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. Any request for restrictions must be made in writing. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any request for a restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you to confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to request to see and get a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you have the right to request that we send a copy of your health information in an electronic format to you. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. We will respond to your request in the timeframe required under applicable law. In certain circumstances, we may deny your request. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to request an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting. Any request for an accounting must be made in writing.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your vision plan website.
- **In certain states, you may have the right to request that we delete your personal information.** Depending on your state of residence, you may have the right to request the deletion of your personal information. We will respond to your request in the timeframe required under applicable law. In certain circumstances, we may deny your request. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Exercising Your Rights

- **Contacting your** *Vision* **Plan.** If you have any questions about this notice or want information about how to exercise your rights, please call the toll- free member phone number on your *vision* ID card or you may call us at 1-800-638-3120, or TTY 711.
- **Submitting a Written Request.** To exercise any of your rights described above, mail your written requests to us at the following address:

UnitedHealthcare

Vision HIPAA - Privacy Unit

PO Box 30978

Salt Lake City, UT 84130

- **Filing a Complaint or Grievance.** If you believe your privacy rights have been violated, you may file a complaint or grievance with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

[1]This Vision Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: UnitedHealthcare Insurance Company and UnitedHealthcare Insurance Company of New York. This list of vision plans is complete as of the effective date of this notice. For a current list of vision plans subject to this notice go to www.uhc.com/privacy/entities-fn-v3.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2025:

We[2] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your vision plan ID card or call us at 1-800-638-3120, or TTY 711.

[2]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the last page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliate: Spectera, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to any other UnitedHealth Group health plans in states that

provide exceptions for HIPAA covered entities or health insurance products. For a current list of vision plans subject to this notice go to www.uhc.com/privacy/entities-fn-v3.