YOUR BENEFIT PLAN

WA State Health Care Authority PEBB

All eligible PEBB Subscribers who elect MetLife Vision Insurance

Vision Insurance for Members

Certificate Date: January 1, 2025

Certificate Number 1

For Subscribers who are residents of states other than Washington: Please refer to the notices following the end of this certificate for important information as to how the provisions of this certificate may vary for the state of which the Subscriber is a resident.

WA State Health Care Authority PEBB
626 8th Avenue SE
P.O. Box 42684
Olympia, WA 98504-2684

TO SUBSCRIBERS:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

WA State Health Care Authority PEBB

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that Members are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to the Subscriber under the Group Policy and it includes the terms and provisions of the Group Policy that describe the Member's insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a legal contract between MetLife and the Policyholder and may be changed or ended without the Subscriber's consent or notice to the Subscriber.

Policyholder:	WA State Health Care Authority PEBB
Group Policy Number:	164995-2-G
Type of Insurance:	Vision Insurance
MetLife Toll Free Number(s):	
For Claim Information	FOR VISION CLAIMS: 1-866-548-7139

THIS CERTIFICATE ONLY DESCRIBES VISION INSURANCE.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

NOTICE FOR RESIDENTS OF ALL STATES WHO ARE INSURED FOR VISION INSURANCE

Notice Regarding the Member's Rights and Responsibilities

Rights:

- We will treat communications, financial records and records pertaining to the Member's care in accordance with all applicable laws relating to privacy.
- Decisions with respect to vision treatment are the responsibility of the Member and the Vision Provider. We neither require nor prohibit any specified treatment. However, only certain specified services are covered for benefits. Please see the Vision Insurance sections of this certificate for more details.
- The Member may request a written response from MetLife to any written concern or complaint.

Responsibilities:

- The Member is responsible for the prompt payment of any charges for services performed by the Vision Provider not fully covered by your Vision Insurance.
- The Member should consult with the Vision Provider about treatment options, proposed and potential procedures, anticipated outcomes, potential risks, anticipated benefits and alternatives. The Member should share with the Vision Provider the most current, complete and accurate information about the Member's medical and vision history and current conditions and medications.
- The Member should follow the treatment plans and health care recommendations agreed upon by the Member and the Vision Provider.

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. Members will only be insured for the benefits:

- for which Members become and remain eligible;
- which the Subscriber elects, if subject to election; and
- which are in effect.

BENEFIT BENEFIT AMOUNTS AND HIGHLIGHTS

Vision Insurance For Members

Adults:

Service Interval	Exam	Lenses	Frame	Contacts
	Once per Calendar Year	Once Every Odd Calendar Year	Once Every Odd Calendar Year	Once Every Odd Calendar Year

Children (to age 19):

Service Interval	Exam	Lenses	Frame	Contacts
	Once per Calendar Year	Once per Calendar Year	Once per Calendar Year	Once per Calendar Year

Exam In-Network Co-Pay	$0
Materials In-Network Co-Pay *Co-payment shall not apply to Elective Contact Lenses*	$0

	In-Network Coverage (Using an In-Network Vision Provider[2])	Out-of-Network Coverage (Using an Out-of-Network Vision Provider)	
EYE EXAMINATION (one per Service Interval)	**Covered in full** Comprehensive examination of visual functions and prescription of corrective eyewear.	**Covered up to $45 allowance** Comprehensive examination of visual functions and prescription of corrective eyewear.	
RETINAL IMAGING	A co-pay amount up to $39. The Member will not be responsible for an amount charged in excess of $39. If the amount charged is under $39, then the Member will only pay the amount that is charged. Coverage for retinal imaging is an enhancement to eye examination. Retinal imaging is not available at all provider locations – contact the Member's In-Network Vision Provider to see if this technology (or equipment or service) is available.	Applied to the allowance for the eye examination	
STANDARD CORRECTIVE LENSES	**Covered in full** Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)	Single Vision	$30 allowance
		Lined Bifocal	$50 allowance
		Lined Trifocal	$65 allowance
		Lenticular	$100 allowance

SCHEDULE OF BENEFITS (continued)

	In-Network Coverage (Using an In-Network Vision Provider[2])		Out-of-Network Coverage (Using an Out-of-Network Vision Provider)
STANDARD LENS OPTIONS	Ultraviolet Coating	Covered in full	Applied to the allowance for the applicable corrective lens
	Polycarbonate (child up to age 19)	Covered in full	
	Scratch Resistant Coating (child up to age 19)	Covered in full	
	Hi Index (child up to age 19)	Covered in full	
	Standard Progressive	Covered in full	$50 allowance
	Premium Progressive: $95-$105 Polycarbonate (adults): $35 Scratch Resistant Coating (adults 19+): $17-$33 Hi Index (adults 19+): 20% discount Anti-Reflective Coating: $41-$85 Tints: $17-$44 Photochromic: $75 Polarized: 20% off retail Note: All lens options are available at a network vision provider, and not to exceed maximum member out of pocket amounts and pricing are subject to change without notice. Please check with your provider for details and maximum member out of pocket amounts applicable to your lens choice. At this time, all lens options and "not to exceed" maximum member out of pocket amounts and pricing are not available at Costco, Walmart and Sam's Club. Please contact your local Costco, Walmart and Sam's Club to confirm the availability of lens options and pricing prior to receiving services.		$50 allowance for Premium Progressive For Polycarbonate (adult), Scratch Resistant Coating (adult), Anti-Reflective Coating, Tints, Photochromatic, and Polarized applied to the allowance for the applicable corrective lens
FRAMES	**Covered up to a $200 allowance** Frames are covered up to the allowance of $110 at Costco, Walmart, and Sam's Club and $200 at other optical retail locations. In-Network Vision Providers prescribe and/or order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.		**Covered up to a $70 allowance**

SCHEDULE OF BENEFITS (continued)

CONTACT LENSES		
FITTING AND EVALUATION	**Subscriber and Spouse or State-Registered Domestic Partner and Children 19+:** **Standard and Premium fit:** Covered in full after a Co-Pay of $60. **Children up to age 19:** **Covered in full**	**Applied to the allowance for the contact lenses**
ELECTIVE	**Subscriber and Spouse or State-Registered Domestic Partner and Children 19+:** **Covered up to $200** Contact lenses are provided in place of lens and frame benefits available herein. **Children up to age 19:** **Covered up to $300** Contact lenses are provided in place of lens and frame benefits available herein.	**Covered up to $105** Contact lenses are provided in place of lens and frame benefits available herein.
NECESSARY	**Covered in full after material Co-payment** Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Vision Provider. Contact lenses are provided in place of lens and frame benefits available herein.	**Covered up to $210** Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Vision Provider. Contact lenses are provided in place of lens and frame benefits available herein.

SCHEDULE OF BENEFITS (continued)

Value-Added Features Available At In-Network Vision Providers[2] (These features are not insurance.)	
REFRACTIVE SURGERY DISCOUNT	Savings averaging 15% off the regular price, or 5% off a promotional offer, for Refractive Surgery. Please check with the Member's provider for details applicable to their Refractive Surgery and which discount ("savings") the Member would be eligible for. This is considered a negotiated discount a negotiated discount for the Member. The Member is responsible for the full amount of the service, less the provider discount.
ADDITIONAL SAVINGS ON GLASSES AND SUNGLASSES	20% savings on additional pairs of prescription glasses and nonprescription sunglasses, including lens enhancements.[1]
ADDITIONAL SAVINGS ON LENS ENHANCEMENTS	Average 20-25% savings on all lens enhancements not otherwise covered under the MetLife Vision Insurance program.[1]
ADDITIONAL SAVINGS ON FRAMES	20% off any amount over your frames allowance. [1]
ADDITIONAL ALLOWANCE ON FEATURED FRAMES	For certain frames, an additional $20 allowance. [1]

[1] These features may not be available in all states and with all In-Network Vision Providers. Please check with the Member's In-Network Vision Provider.
[2] As provided by Vision Service Plan Choice Network. The network is located throughout the United States. Services by network or non-network providers will be covered throughout the United States. Emergency vision services provided outside the United States are covered on an out-of-network basis.

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Anisometropia means a condition of unequal refractive state of the two eyes, one eye requiring a different lens correction than the other.

Annual Open Enrollment means a period of time defined by HCA when a Subscriber may change to another health plan offered by the PEBB Program and make certain other account changes for an effective date beginning January 1 of the following year.

Continuation Coverage means the temporary continuation of PEBB benefits available to enrollees under the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Uniformed Services Employment and Reemployment Rights Act (USERRA), or PEBB policies.

Co-Payment or **Co-Pay** means a fixed dollar amount for which We are not responsible, as shown in the Schedule of Benefits. The Member must pay the Member's Co-Payment at the time services are rendered or materials ordered.

Covered Person(s) means an eligible employee, retiree, survivor, Continuation Coverage Subscriber, Retired Employee of a Former Employer Group, or a Dependent covered under this Certificate.

Covered Services and Materials mean a vision service or materials used to treat Member's vision condition which is:

- prescribed or performed by a Vision Provider while such person is insured for Vision Insurance;
- Necessary to treat the condition; and
- described in the SCHEDULE OF BENEFITS or VISION INSURANCE: DESCRIPTION OF COVERED SERVICES AND MATERIALS sections of this certificate.

Dependent(s) means the Subscriber's eligible Spouse or State-Registered Domestic Partner as defined in this DEFINITIONS section, and/or child as described in the Dependent eligibility section of this certificate.

Employing Agency means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, or other political subdivision; and a tribal government covered by HCA statute.

Employer Group means:

- for the School Employees Benefits Board (SEBB) Program, an employee organization representing school employees and a tribal school as defined in state statute and rules, obtaining school employee benefits through a contractual agreement with the HCA to participate in benefit plans developed by the SEB board; and
- for the Public Employees Benefits Board (PEBB) Program, those counties, municipalities, political subdivisions, the Washington health benefits exchange, tribal governments, and employee organizations representing state civil service employees obtaining employee benefits through a contractual agreement with the HCA to participate in benefit plans developed by the PEB board.

Enrollee means an a person covered under this plan as a Subscriber or Dependent.

Health Care Authority (HCA) means the Washington State Agency that administers the PEBB and SEBB Programs.

In-Network Vision Provider means a Vision Provider who is contracted to provide Plan Benefits to Covered Persons of MetLife and accepts reimbursement at the negotiated rate. The In-Network Vision Provider is: Vision Service Plan Choice Network

DEFINITIONS (continued)

Keratoconus means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area.

Maximum Benefit Allowance means the maximum amount We will allow for Covered Services and Materials provided by a Vision Provider.

Member means a person covered under this plan as a Subscriber or Dependent.

Necessary means Covered Services and Materials that are necessary and meet with professionally recognized standards of practice. The fact that a Vision Provider may prescribe, order, recommend or approve a service or material does not, in itself, make it medically necessary, or make it a Covered Service and Material even though it is listed in the Group Policy or the Benefit Schedule as Covered Service and Material.

Out-of-Network Vision Provider/Non-Network Vision Provider means a Vision Provider who has not contracted to provide vision care services and/or vision care materials to Covered Persons of MetLife.

Plan or **Plan Benefits** means the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Certificate.

Progressive Lens means a multifocal lens that makes the transition from distance to near vision by a gradual, progressive addition of power. The result is a lens with a seamless appearance.

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Public Employees Benefits Board (PEBB) means a group of representatives, appointed by the governor, who approves insurance benefit plans for employees and their Dependents, and establishes eligibility criteria for participation in insurance benefit plans.

Public Employees Benefits Board (PEBB) Program means the HCA program that administers PEBB benefit eligibility and enrollment.

Retired Employee of a Former Employer Group means a retired employee from a PEBB Employer Group and a retired school employee from a SEBB Employer Group continuing enrollment in PEBB health plan coverage after losing eligibility due to the Employer Group ending participation in insurance plans and contracts with the HCA.

School Employees Benefits Board (SEBB) means a group of representatives, appointed by the governor, who designs and approves insurance benefit plans for school employees and their Dependents, and establishes eligibility criteria for participation in insurance benefit plans.

School Employees Benefits Board (SEBB) Organization means a public school district or educational service district or charter school established under Washington State statute that is required to participate in benefit plans provided by the School Employees Benefits Board (SEBB).

DEFINITIONS (continued)

School Employees Benefits Board (SEBB) Program means the program within HCA that administers insurance and other benefits for eligible school employees, eligible school board members, and eligible Dependents.

Service Interval means a period of consecutive months, as shown in the SCHEDULE OF BENEFITS, in which Members may receive Covered Services and Materials. This period starts on the Member's effective date of coverage. A subsequent service interval starts after vision services or materials are received. Once Covered Services and Materials are received during any service interval, additional services are not covered during the same service interval and are subject to an additional charge.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means the Subscriber's legal spouse.

For the purposes of determining who may become covered for insurance, the term does not include any person who is insured under the Group Policy as a Subscriber.

State Agency means an office, department, board, commission, institution, or other separate unit or division, however designated, of the Washington state government. It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

State-Registered Domestic Partner means two adults who meet the requirements for a valid state-registered domestic partnership, and enter into a state-registered domestic partnership, in the State of Washington; or a legal union, other than marriage, of two persons that was validly formed in a jurisdiction other than the State of Washington and that is substantially equivalent to a domestic partnership in the State of Washington.

For the purposes of determining who may become covered for insurance, the term does not include any person who is insured under the Group Policy as a Subscriber.

Subscriber means an eligible employee, retiree, survivor, Continuation Coverage Enrollee, or Retired Employee of a Former Employer Group who has been determined eligible and is insured under this group policy, and is the individual to whom the PEBB Program or We will issue notices, information, requests, and premium bills on behalf of an Enrollee or Covered Person.

Vision Provider means an eye care professional who is an optometrist, ophthalmologist, or registered dispensing optician, who:

- Is licensed as such by the proper authorities in the jurisdiction where such services are performed; and
- Is acting within the scope of such license.

We, Us and **Our** mean MetLife.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Year or **Yearly**, for Vision Insurance, means the 12 month period that begins January 1.

ELIGIBILITY PROVISIONS: INSURANCE FOR THE SUBSCRIBER AND THE SUBSCRIBER'S DEPENDENTS

PEBB

VISION PLAN ELIGIBILITY AND ENROLLMENT

ELIGIBLE CLASS(ES)

All eligible PEBB Subscribers who elect MetLife Vision Insurance.

DATE THE SUBSCRIBER IS ELIGIBLE FOR INSURANCE

The Subscriber may only become eligible for the insurance available for the Subscriber's eligible class as shown in the SCHEDULE OF BENEFITS.

If the Subscriber is in an eligible class on January 1, 2025, the Subscriber will be eligible for the insurance described in this certificate on that date.

If the Subscriber enters an eligible class after January 1, 2025, the Subscriber will be eligible for insurance on the date the Subscriber enters that class.

In these sections, the term "retiree" or "retiring employee" includes a retiring employee from a Public Employees Benefits Board (PEBB) Employing Agency or Employer Group, and an elected or full-time appointed official of the legislative and executive branch of state government. The term "retiree" or "retiring school employee" includes a retiring school employee from a School Employees Benefits Board (SEBB) organization or Employer Group. Additionally, "health plan" is used to refer to a plan offering medical, dental, vision, or any combination of these coverages, developed by PEBB and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

ELIGIBILITY FOR SUBSCRIBERS AND DEPENDENTS

Employee eligibility

This vision plan is available to all employees and their eligible dependents if their Employing Agency offers this benefit.

The employee's State Agency will inform the employee in writing whether they are eligible for PEBB benefits upon employment and whenever their eligibility status changes. The written notice will include information about the employee's right to appeal eligibility and enrollment decisions.

An employee of an Employer Group (such as a county, city, port, water district, etc.) that contracts with HCA for PEBB benefits should contact their payroll or benefits office for eligibility criteria.

Employees have the right to appeal eligibility and enrollment decisions. Information about appeals can be found under "Appeal rights."

Continuation coverage eligibility

This vision plan is available to Unpaid Leave continuation coverage subscribers and their eligible dependents. This vision plan is also available to COBRA continuation coverage subscribers or their eligible dependents who are not enrolled in a PEBB Medicare medical plan.

The PEBB Program determines whether subscribers are eligible for continuation coverage (COBRA or Unpaid Leave) upon receipt of their election to enroll. If the subscriber requests to enroll in and is not eligible for continuation coverage, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under "Appeal rights."

ELIGIBILITY PROVISIONS: INSURANCE FOR THE SUBSCRIBER AND THE SUBSCRIBER'S DEPENDENTS (continued)

Retired Employee of a Former Employer Group eligibility

This vision plan is only available to a Retired Employee of a Former Employer Group or their eligible dependents who are not enrolled in a PEBB Medicare medical plan.

The PEBB Program determines whether a retired employee or a retired school employee of a former Employer Group is eligible to self-pay coverage in PEBB Continuation Coverage (Employer Group Ended Participation) upon receipt of their election to enroll. If the retired employee or the retired school employee requests to enroll and is not eligible, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under "Appeal rights."

Retiree and survivor eligibility

This vision plan is only available to a retiree, a survivor, or their eligible dependents who are not enrolled in a PEBB Medicare medical plan.

Retiree: The PEBB Program determines if a retiring employee or retiring school employee is eligible to enroll in PEBB retiree insurance coverage upon receipt of their election to enroll. If the retiring employee or retiring school employee does not have substantive eligibility or does not meet the procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to appeal eligibility decisions. Information about appeals can be found under "Appeal rights."

Survivor: The PEBB Program determines whether a dependent is eligible to enroll or continue enrollment in PEBB retiree insurance coverage as a survivor. If an election to enroll is required, eligibility will be determined upon receipt of their election to enroll. If the survivor does not meet the eligibility and procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to appeal. Information about appeals can be found under "Appeal rights."

Dependent eligibility

The following are eligible dependents:

- Legal spouse
- State-registered domestic partner and substantially equivalent legal unions from jurisdictions as defined in Washington State statute. Individuals in a state-registered domestic partnership are treated the same as a legal spouse except when in conflict with federal law.
- Children, through the last day of the month in which their 26th birthday occurred regardless of marital status, student status, or eligibility for coverage under another plan. It also includes children age 26 or older with a disability as described below in "Children of any age with a developmental or physical disability." Children are defined as the subscriber's:
  - **Children based on establishment of a parent-child relationship**, as described in Washington State statutes, except when parental rights have been terminated.
  - **Children of the subscriber's spouse**, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death.
  - **Children for whom the subscriber has assumed a legal obligation** for total or partial support in anticipation of adoption of the child.
  - **Children of the subscriber's state-registered domestic partner,** based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death.
  - **Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage.**

- **Extended dependents in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner.** The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include foster children unless the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.
- **Children of any age with a developmental or physical disability** that renders them incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance, provided such condition occurs before the age of 26. The following requirements apply to a dependent child with a disability:

    - The subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26.
    - The subscriber must notify the PEBB Program in writing when the child is no longer eligible under this subsection.
    - A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month in which they become capable of self-support.
    - A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility if they later become incapable of self-support.
    - The PEBB Program (with input from the medical plan, if enrolled in medical) will periodically verify the eligibility of a dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday. Verification will require renewed proof of disability and dependence from the subscriber.

A retiree, a survivor, or their enrolled dependents are required to enroll and stay enrolled in Medicare Part A and Part B, if eligible. This is a condition of their enrollment in a PEBB retiree health plan. A retiree or survivor must provide a copy of their or their dependent's Medicare card or Medicare benefit verification letter with Medicare Part A and Part B effective dates to the PEBB Program as proof of enrollment in Medicare. If a retiree, a survivor, or their dependent is not enrolled in either Medicare Part A or Part B on their 65th birthday, the retiree or survivor must provide the PEBB Program with a copy of the denial letter from the Social Security Administration. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

When a retiree, a survivor, or their enrolled dependent enrolls in Medicare Part A and Part B, they will no longer be eligible for this vision plan. In most cases, vision coverage will be included under their PEBB Medicare medical plan. Any non-Medicare Enrollees may remain enrolled in this vision plan.

ENROLLMENT FOR SUBSCRIBERS AND DEPENDENTS

For all subscribers and dependents

- To enroll at any time other than during the initial enrollment period, see "Making changes."
- Any dependents enrolled in PEBB vision will be enrolled in the same vision plan as the subscriber, except when a retiree, a survivor, a COBRA continuation coverage subscriber, or a Retired Employee of a Former Employer Group is enrolled in a PEBB Medicare plan.

Employee enrollment

An employee is required to enroll in PEBB vision unless otherwise described in PEBB Program rules. An employee must use Benefits 24/7, the online enrollment system, or submit a PEBB Employee Enrollment/Change form and any supporting documents to their Employing Agency when they become newly eligible or regain eligibility for PEBB benefits. The online enrollment must be completed or the forms must be received no later than 31 days after the date the employee becomes eligible or regains eligibility.

If the employee does not enroll online or return the form by the deadline, the employee will be enrolled in Metropolitan Life Vision Plan. Dependents cannot be enrolled until the PEBB Program's next annual open enrollment or when a qualifying event occurs that creates a special open enrollment that allows enrolling a dependent. See "Special open enrollment changes."

ELIGIBILITY PROVISIONS: INSURANCE FOR THE SUBSCRIBER AND THE SUBSCRIBER'S DEPENDENTS (continued)

Continuation coverage and retired employees of a former Employer Group enrollment

A continuation coverage subscriber, a retired employee or retired school employee of a former Employer Group or their dependent can enroll in only one PEBB vision plan, even if eligibility criteria is met under two or more subscribers.

A subscriber enrolling in PEBB Continuation Coverage (COBRA or Unpaid Leave) and retired employees or retired school employees of a former Employer Group may enroll by using Benefits 24/7, the online enrollment system, or by submitting the applicable *PEBB* Continuation Coverage Election/Change form and any supporting documents to the PEBB Program.

For PEBB Continuation Coverage, the online enrollment must be completed or the PEBB Program must receive the election form no later than 60 days from the date the Enrollee's PEBB health plan coverage ended or from the postmark date on the PEBB Continuation Coverage Election Notice sent by the PEBB Program, whichever is later. For retired employees of a former Employer Group, the online enrollment must be completed or the PEBB Program must receive the required form no later than 60 days after the Employer Group's date of termination.

Premiums and applicable premium surcharges must be made directly to HCA. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends as described above. For more information, see "Options for continuing PEBB vision coverage" and the *PEBB* Continuation Coverage Election Notice.**Retiree and survivor enrollment**

An eligible retiree or survivor must enroll in PEBB medical to enroll in PEBB vision. An eligible retiree, a survivor, or their dependent can enroll in only one PEBB vision plan, even if eligibility criteria is met under two or more subscribers.

An eligible retiring employee or a retiring school employee must enroll using Benefits 24/7, the online enrollment system, or submit a PEBB Retiree Election Form (form A) along with any other required forms and supporting documents to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the employee's or the school employee's own employer-paid coverage, COBRA coverage, or continuation coverage ends. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible elected or full-time appointed official must enroll using Benefits 24/7, the online enrollment system, or submit a PEBB Retiree Election Form (form A) along with any other required forms and supporting documents to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the official leaves public office. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible survivor of a retiree who is enrolled at the time of the retiree's death will be enrolled in the same PEBB health plan coverage they were enrolled in under their own account with no gap in coverage. To make changes to their PEBB health plan coverage, they must submit a PEBB Retiree Election Form (form A) along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the death of the retiree. An eligible survivor of a retiree who is not enrolled at the time of the retiree's death must submit a PEBB Retiree Election Form (form A) along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the death of the retiree.

An eligible survivor of an employee or school employee must submit a PEBB Retiree Election Form (form A) along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 60 days after the later of the date of the employee's or the school employee's death, or the date the survivor's PEBB insurance coverage or SEBB insurance coverage ends. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible employee or school employee determined to be retroactively eligible for disability retirement must enroll using Benefits 24/7, the online enrollment system, or submit a PEBB Retiree Election Form (form A) along with any other required forms, supporting documents, and their formal determination letter to the PEBB Program. The online enrollment must be completed or the forms must be received no later than 60 days after the date on the determination letter. The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

An eligible survivor of an emergency service personnel killed in the line of duty must submit a PEBB Retiree Election Form (form A) along with any other required forms and supporting documents to the PEBB Program. They must be received no later than 180 days after the later of:

- The date on the letter from the Department of Retirement Systems or the Board for Volunteer Firefighters and Reserve Officers that informs the survivor that they are determined to be an eligible survivor;
- The date of the emergency service worker's death; or
- The last day the survivor was covered under any health plan through the emergency service worker's employer or COBRA coverage from the emergency service worker's employer.

A retiree or a survivor who deferred enrollment and is enrolling in a PEBB retiree health plan must enroll using Benefits 24/7, the online enrollment system, or submit a PEBB Retiree Election Form (form A) along with any other required forms and supporting documents to the PEBB Program.

A retiree or a survivor who deferred enrollment while enrolled in other qualifying coverage must also submit evidence of continuous enrollment. The online enrollment must be completed or the forms must be received no later than 60 days after a loss of other qualifying coverage.

A retiree or a survivor enrolled in Medicare who deferred enrollment while permanently living outside of the United States must also submit proof of enrollment in Medicare Parts A and B; evidence of continuous enrollment in qualified coverage is waived. The online enrollment must be completed or the forms must be received no later than 60 days after the date of the permanent move or the date the retiree or survivor provides notification of such move, whichever is later.

The first premium payment and applicable premium surcharges are due to HCA no later than 45 days after the election period ends.

Dependent enrollment

If a non-Medicare retiree or survivor chooses to enroll in PEBB vision under PEBB retiree insurance coverage, any non-Medicare dependents enrolled will also be enrolled in PEBB vision.

A retiree or survivor enrolled in Medicare Part A and Part B may elect PEBB vision for any non-Medicare dependents they choose to enroll in PEBB retiree insurance coverage. The retiree or survivor, in most cases, will have their vision coverage under their PEBB Medicare medical plan.

If a subscriber chooses to enroll an eligible dependent, the subscriber must include the dependent's information online using Benefits 24/7 or on the applicable enrollment form and provide the required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled in PEBB health plan coverage if the PEBB Program or the Employing Agency is unable to verify their eligibility within the PEBB Program enrollment timelines.

Dual enrollment

A subscriber and their dependents may each be enrolled in only one PEBB vision plan.
An employee or their dependent who is eligible to enroll in both the PEBB Program and the School Employees Benefits Board (SEBB) Program is limited to a single enrollment in either the PEBB or SEBB Program.

For example:

- A child who is an eligible dependent under two parents enrolled in PEBB Program benefits may be enrolled as a dependent under both parents but is limited to a single enrollment in PEBB vision.
- A child who is an eligible dependent of an employee in the PEBB Program and a school employee in the SEBB Program may only be enrolled as a dependent under one parent in either the PEBB or SEBB Program.

MEDICARE ELIGIBILITY AND ENROLLMENT

Employee and dependent

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

Continuation coverage subscriber, a Retired Employee of a Former Employer Group, or their dependent

If a continuation coverage subscriber, a Retired Employee of a Former Employer Group, or their dependent becomes eligible for Medicare, federal regulations allow enrollment in Medicare three months before they turn age 65. If they do not enroll within three months before the month they turn age 65, enrollment in Medicare may be delayed. If enrollment in Medicare does not occur when the subscriber or their dependent is first eligible, a late enrollment penalty may apply.

Retiree or survivor and dependent

If a retiree, a survivor, or their enrolled dependent becomes eligible for Medicare, they should contact the Social Security Administration to ask about Medicare enrollment. The Medicare-eligible subscriber or their dependent must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage. If this procedural requirement is not met, eligibility will end as described in the termination notice sent by the PEBB Program. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

When a retiree, a survivor, or their enrolled dependent enrolls in Medicare Part A and Part B, they will no longer be eligible for this vision plan. In most cases, vision coverage will be included under their PEBB Medicare medical plan. Any non-Medicare Enrollees may remain enrolled in this vision plan.

When a COBRA continuation coverage subscriber, a Retired Employee of a Former Employer Group, or their enrolled dependent enrolls in Medicare Part A and Part B, they may continue coverage under this vision plan if they are not also enrolled in a PEBB Medicare medical plan.

WHEN VISION COVERAGE BEGINS

Employees and dependents

For a newly eligible employee and their eligible dependents, vision coverage begins the first day of the month following the date the employee becomes eligible. If the employee becomes eligible on the first working day of the month, then coverage begins on that date.

If the eligible employee is a faculty member hired on a quarter-to-quarter or semester-to-semester basis, vision coverage begins the first day of the month following the beginning of the second consecutive quarter or semester. If the first day of the second consecutive quarter or semester is the first working day of the month, vision coverage begins on that day.

ELIGIBILITY PROVISIONS: INSURANCE FOR THE SUBSCRIBER AND THE SUBSCRIBER'S DEPENDENTS (continued)

For an employee regaining eligibility, including following a period of leave or after being between periods of leave as described in PEBB Program rules, and their eligible dependents, vision coverage begins the first day of the month the employee is in pay status eight or more hours. If the employee is a faculty member regaining eligibility no later than the 12th month after the month in which they lost eligibility for the employer contribution toward PEBB benefits, vision coverage begins the first day of the month in which the quarter or semester begins.

Note: When an employee who is called to active duty in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act (USERRA) loses eligibility for the employer contribution toward PEBB benefits, they regain eligibility for the employer contribution toward PEBB benefits the day they return from active duty. Vision coverage begins the first day of the month in which the employee returns from active duty.

Retirees and dependents

For an eligible retiring employee or retiring school employee and their eligible dependents, vision coverage begins on the first day of the month after the retiring employee's or the retiring school employee's own employer-paid coverage, COBRA coverage, or continuation coverage ends.

For an eligible employee or school employee determined to be retroactively eligible for disability retirement and their eligible dependents, vision coverage begins on the date chosen by the employee or school employee as allowed under PEBB Program rules.

For an eligible elected or full-time appointed official and their eligible dependents, vision coverage begins the first day of the month following the date the official leaves public office.

For an eligible retiree who deferred enrollment and is enrolling in a PEBB retiree health plan following loss of other qualifying coverage, vision coverage for the retiree and their eligible dependents begins the first day of the month after the other qualifying coverage ends. For a retiree enrolled in Medicare who deferred enrollment while permanently living outside of the United States, vision coverage for their eligible dependents begins the first day of the month after the permanent move or the date the retiree provides notification of such move, whichever is later.

Survivors and dependents

For an eligible survivor of a retiree and their eligible dependents, vision coverage will be continued without a gap, subject to payment of premiums and applicable premium surcharges. If the eligible survivor is not enrolled at the time of the retiree's death, vision coverage will begin the first day of the month following the retiree's death.

For an eligible survivor of an employee or school employee and their eligible dependents, vision coverage begins the first day of the month following the later of the date of the employee's or school employee's death or the date the survivor's PEBB insurance coverage or SEBB insurance coverage ends. This does not include emergency service personnel killed in the line of duty.

For an eligible survivor of emergency service personnel killed in the line of duty and their eligible dependents, vision coverage begins on the date chosen, as allowed under PEBB Program rules.

For an eligible survivor who deferred enrollment and is enrolling in a PEBB retiree health plan following loss of other qualifying coverage, vision coverage for the survivor and their eligible dependents begins the first day of the month after the other qualifying coverage ends. For a survivor enrolled in Medicare who deferred enrollment while permanently living outside of the United States, vision coverage for their eligible dependents begins the first day of the month after the permanent move or the date the survivor provides notification of such move, whichever is later.

Continuation coverage subscribers and dependents

For a continuation coverage subscriber and their eligible dependents enrolling when newly eligible due to a qualifying event, vision coverage begins the first day of the month following the day they lost eligibility for PEBB vision plan coverage.

ELIGIBILITY PROVISIONS: INSURANCE FOR THE SUBSCRIBER AND THE SUBSCRIBER'S DEPENDENTS (continued)

Retired employees of a former Employer Group and dependents

For a Retired Employee of a Former Employer Group and their eligible dependents enrolling when newly eligible, vision coverage begins the first day of the month following the day they lost eligibility for PEBB retiree insurance coverage.

All subscribers and dependents

For a subscriber or their eligible dependents enrolling during the PEBB Program's annual open enrollment, vision coverage begins January 1 of the following year.

For a subscriber or their eligible dependents enrolling during a special open enrollment, vision coverage begins the first day of the month following the later of the event date or the date the online enrollment election using Benefits 24/7 or the required form is received. If that day is the first of the month, vision coverage begins on that day.

If the special open enrollment is due to the **birth or adoption of a child**, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, vision coverage will begin as follows:

- **For an employee,** vision coverage will begin the first day of the month in which the event occurs.
- **For a newly born child,** vision coverage will begin the date of birth.
- **For a newly adopted child,** vision coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier.
- **For a spouse or state-registered domestic partner** of a subscriber, vision coverage will begin the first day of the month in which the event occurs.

If the special open enrollment is due to the enrollment of an **extended dependent or a dependent child with a disability**, vision coverage will begin the first day of the month following the event date or eligibility certification, whichever is later.

MAKING CHANGES

Removing a dependent who is no longer eligible

A subscriber must provide notice to remove a dependent who is no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child as described under "Dependent eligibility." The notice must be received within 60 days of the last day of the month the dependent no longer meets the eligibility criteria.

- **An employee** must provide notice online using Benefits 24/7 or by submitting a written request to their Employing Agency.
- **Any other subscriber** must provide notice online using Benefits 24/7 or by submitting a written request to the PEBB Program.

Consequences for not submitting notice within the required 60 days may include, but are not limited to:

- The dependent may lose eligibility to continue PEBB vision under one of the continuation coverage options described in "Options for continuing PEBB vision coverage."
- The subscriber may be billed for claims paid by the vision plan for services that were rendered after the dependent lost eligibility.
- The subscriber may not be able to recover subscriber-paid insurance premiums for the dependent that lost eligibility.
- The subscriber may be responsible for premiums paid by the state for the dependent's vision plan coverage after the dependent lost eligibility.

Voluntary termination for a retiree, a survivor, a continuation coverage subscriber, or a Retired Employee of a Former Employer Group

A retiree, a survivor, a continuation coverage subscriber, or a Retired Employee of a Former Employer Group may voluntarily terminate enrollment in a vision plan at any time by submitting a request online using Benefits 24/7 or in writing to the PEBB Program. Enrollment in the vision plan will be terminated the last day of the month in which the request was received online or by the PEBB Program, or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, vision plan enrollment will be terminated on the last day of the previous month.

A retiree or a survivor who voluntarily terminates their enrollment in PEBB vision also terminates vision enrollment for all eligible dependents.

Making changes during annual open enrollment and special open enrollment

A subscriber may make certain changes to their enrollment during the annual open enrollment and if a specific life event creates a special open enrollment period.

Annual open enrollment changes

An employee may make the following changes to their enrollment during the PEBB Program's annual open enrollment period:

- Enroll or remove eligible dependents
- Change their vision plan

An employee must submit the election change online using Benefits 24/7 or return the required *PEBB Employee Enrollment/Change* form and any supporting documents to their Employing Agency. The change must be completed online, or the forms received, no later than the last day of the annual open enrollment period and will be effective January 1 of the following year.

Any other subscriber may make the following changes to their enrollment during the PEBB Program's annual open enrollment period:

- Enroll in or terminate enrollment in a vision plan
- Enroll or remove eligible dependents
- Change their vision plan

They must submit the election change online using Benefits 24/7 or return the required PEBB Retiree Open Enrollment Election/Change Form (form A-OE) or PEBB Continuation Coverage Election/Change form (*as* appropriate) and any supporting documents to the PEBB Program. The change must be completed online, or the forms received, no later than the last day of the annual open enrollment period. The change will be effective January 1 of the following year.

Special open enrollment changes

A subscriber may change their enrollment outside of the annual open enrollment period if a qualifying event creates a special open enrollment period. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, their dependent, or both.

A special open enrollment event must be other than an employee gaining initial eligibility or regaining eligibility for PEBB benefits. The subscriber must provide evidence of the event that created the special open enrollment.

A special open enrollment may allow a subscriber to make the following changes:

- Enroll in or change their vision plan
- Enroll or remove eligible dependents

To request a special open enrollment:

- **An employee** must make the change online using Benefits 24/7 or submit the required PEBB Employee Enrollment/Change form and any supporting documents to their Employing Agency.
- **Any other subscriber** must make the change online using Benefits 24/7 or submit the required PEBB Retiree Change Form (form E) or PEBB Continuation Coverage Election/Change form (as appropriate) and any supporting documents to the PEBB Program.

The change must be completed online, or the forms must be received, no later than 60 days after the event that creates the special open enrollment. In addition, the PEBB Program or the Employing Agency will require the subscriber to provide proof of a dependent's eligibility, evidence of the event that created the special open enrollment, or both.

Note: If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption in PEBB health plan coverage, the subscriber should complete the request online or notify their Employing Agency or the PEBB Program by submitting the required forms as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the request must be received online, or the required forms must be received, no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

Special open enrollment events that allow for a change in health plans

A subscriber may not change their health plan during a special open enrollment if their state-registered domestic partner or state-registered domestic partner's child is not a tax dependent.
Any of the following events may create a special open enrollment:

- Subscriber gains a new dependent due to:
  - Marriage or registering a state-registered domestic partnership.
  - Birth, adoption, or assuming a legal obligation for total or partial support in anticipation of adoption.
  - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber has a change in residence and their current medical plan is no longer available, the subscriber must select a new medical plan as described in PEBB Program rules.
- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP) or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.

- Subscriber or their dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber or their dependent enrolls in coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare or enrolls in or terminates enrollment in a Medicare Advantage Prescription Drug or a Part D plan. If the subscriber's current medical plan becomes unavailable due to the subscriber or their dependent's enrollment in Medicare, the subscriber must select a new medical plan.
- Subscriber or their dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA).
- Subscriber or their dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent. The subscriber may not change their health plan election because the subscriber or dependent's physician stops participation with the subscriber's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but not limit its consideration to the following:
  - Active cancer treatment, such as chemotherapy or radiation therapy
  - Treatment following a recent organ transplant
  - A scheduled surgery
  - Recent major surgery still within the postoperative period
  - Treatment for a high-risk pregnancy
- The PEBB Program determines that there has been a substantial decrease in the providers available under a PEBB medical plan.

Note: The plan cannot guarantee that any physician, hospital, or other provider will be available or remain under contract with the plan. An Enrollee may not change vision plans simply because their provider or health care facility discontinues participation with this vision plan until the PEBB Program's next annual open enrollment or when another qualifying event creates a special open enrollment for changing health plans, unless the PEBB Program determines that a continuity of care issue exists.

Special open enrollment events that allow adding or removing a dependent

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

- Subscriber gains a new dependent due to:
  - Marriage or registering a state-registered domestic partnership.
  - Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption.
  - A child becoming eligible as an extended dependent through legal custody or legal guardianship.
- Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
- Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan.
- Subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan. "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in the Treasury Regulation.
- Subscriber or their dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment.
- Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence resulted in the dependent losing their health insurance.

- A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent).
- Subscriber or their dependent enrolls in coverage under Medicaid or a state Children's Health Insurance Program (CHIP) or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP.
- Subscriber or their dependent becomes eligible for a state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.
- Subscriber's dependent enrolls in Medicare or loses eligibility for Medicare.

WHEN VISION COVERAGE ENDS

Termination dates

Vision coverage ends on the following dates:

- On the last day of the month when any Enrollee ceases to be eligible.
- On the date a vision plan terminates or when the group policy ends. If that should occur, the subscriber will have the opportunity to enroll in another PEBB vision plan.
- **For an employee** and their dependents, on the last day of the month the employment relationship is terminated. The employment relationship is considered terminated:
  - On the date specified in an employee's letter of resignation.
  - On the date specified in any contract or hire letter.
  - On the effective date of an employer-initiated termination notice.

Note: If the Employing Agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, vision coverage ends the last day of the month for which employee premiums were deducted.

- **For a retiree, a survivor, a continuation coverage subscriber, or a Retired Employee of a Former Employer Group** who submits a request to terminate vision coverage, enrollment in vision coverage will be terminated the last day of the month in which the request was received online using Benefits 24/7 or by the PEBB Program, or on the last day of the month specified in the termination request, whichever is later. If the request is received on the first day of the month, vision coverage will be terminated on the last day of the previous month.

A subscriber will be responsible for payment of any services received after the date vision coverage ends, as described above.

Final Premium Payments

Premium payments and applicable premium surcharges are not prorated during any month, for any reason, even if an Enrollee dies or asks to terminate their vision plan before the end of the month.

An exception occurs when an enrolled retiree dies on or after June 6, 2024. A state law that took effect June 6, 2024, requires HCA to waive the premium payment for medical, dental, vision, and any applicable premium surcharges for the retiree for the month in which the death occurred.

If the monthly premium or applicable premium surcharges remain unpaid for 30 days, the account will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premiums or applicable premium surcharges become delinquent to pay the unpaid premium balance and applicable premium surcharges. If the subscriber's premium balance or applicable premium surcharges remain unpaid for 60 days from the original due date, the subscriber's vision coverage (including enrolled dependents) will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges were paid.

ELIGIBILITY PROVISIONS: INSURANCE FOR THE SUBSCRIBER AND THE SUBSCRIBER'S DEPENDENTS (continued)

Options for continuing PEBB vision coverage

When vision coverage ends, the subscriber and their dependents covered by this vision plan may be eligible to continue PEBB vision coverage during temporary or permanent loss of eligibility.

There are three options the subscriber and their dependents may qualify for when coverage ends.

- PEBB Continuation Coverage (COBRA)
- PEBB Continuation Coverage (Unpaid Leave)
- PEBB retiree insurance coverage

PEBB Continuation Coverage

The PEBB Program administers the following continuation coverage options that temporarily extend group insurance coverage when the Enrollee's PEBB vision plan coverage ends due to a qualifying event:

- **PEBB Continuation Coverage (COBRA)** includes eligibility and administrative requirements under federal COBRA laws and regulations. Some Enrollees who are not qualified beneficiaries under federal COBRA may also qualify for PEBB Continuation Coverage (COBRA). When a COBRA continuation coverage subscriber or their dependent enrolls in Medicare Part A and Part B, they may continue coverage under this vision plan if they are not also enrolled in a PEBB Medicare medical plan.
- **PEBB Continuation Coverage (Unpaid Leave)** is an option created by the PEBB Program with wider eligibility criteria and qualifying event types than COBRA.

An Enrollee who qualifies for both types of PEBB Continuation Coverage (COBRA and Unpaid Leave) may enroll in only one of these options. See "Continuation coverage enrollment" and the PEBB Continuation Coverage Election Notice.

Premium payments for PEBB Continuation Coverage

If a subscriber enrolls in continuation coverage, the subscriber is responsible for timely payment of premiums and applicable premium surcharges.

The PEBB Program also administers continued health plan enrollment under PEBB Continuation Coverage (Employer Group Ended Participation) for a retired employee or a retired school employee and their dependents covered by this vision plan who lose eligibility for PEBB retiree insurance coverage when their Employer Group ends participation with the Health Care Authority. Contact the PEBB Program at 1-800-200-1004 (TRS: 711) for details.

PEBB retiree insurance coverage

A retiring employee, a retiring school employee, an eligible elected or full-time appointed official of the legislative or executive branch of state government leaving public office, a dependent becoming eligible as a survivor, or a retiree or a survivor enrolled in PEBB retiree insurance coverage is eligible to continue enrollment or defer enrollment in PEBB retiree insurance coverage, if they meet procedural and substantive eligibility requirements. See the PEBB Retiree Enrollment Guide for details. Enrollment in a vision plan under PEBB retiree insurance coverage is only available for Enrollees who are not enrolled in Medicare Part A and Part B.

Family and Medical Leave Act of 1993

An employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward PEBB benefits in accordance with the federal FMLA.

The Employing Agency determines if the employee is eligible for leave and the duration of the leave under FMLA. The employee must continue to pay their monthly premium contribution and applicable premium surcharges during this period to maintain eligibility.

If an employee exhausts the period of leave approved under FMLA, they may continue PEBB insurance coverage by self-paying the monthly premium and applicable premium surcharges set by HCA, with no contribution from the Employing Agency. See "Options for continuing PEBB vision coverage."

Paid Family and Medical Leave Act

An employee on approved leave under the Washington State Paid Family and Medical Leave (PFML) Program may continue to receive the employer contribution toward PEBB benefits.

The Employment Security Department determines if the employee is eligible for leave under PFML. The employee must continue to pay their monthly premium contribution and applicable premium surcharges during this period to maintain eligibility.

If an employee exhausts the period of leave approved under PFML, they may continue PEBB insurance coverage by self-paying the monthly premium and applicable premium surcharges set by HCA, with no contribution from the Employing Agency. See "Options for continuing PEBB vision coverage."

GENERAL PROVISIONS FOR ELIGIBILITY AND ENROLLMENT

Payment of premiums during a labor dispute

Any employee or dependent whose monthly premiums are paid in full or in part by the Employing Agency may pay premiums directly to HCA if the employee's compensation is suspended or terminated directly or indirectly because of a strike, lockout, or any other labor dispute, for a period not to exceed six months.

When the employee's compensation is suspended or terminated, HCA will notify the employee immediately (by mail at the last address of record) that the employee may pay premiums as they become due.

If coverage is no longer available to the employee under this certificate of coverage, then the employee may be eligible to purchase an individual vision plan from this plan consistent with premium rates filed with the Washington State Office of the Insurance Commissioner.

Termination for just cause

The purpose of this provision is to allow for a fair and consistent method to process the plan-designated provider's request to terminate an Enrollee's coverage from this plan for just cause.

A retiree or an eligible dependent may have coverage terminated by HCA for the following reasons:

- Failure to comply with the PEBB Program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB Program
- Knowingly providing false information
- Failure to pay the monthly premium and applicable premium surcharges when due
- Misconduct. Examples of such termination include, but are not limited to the following:
    - Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium
    - Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan, or other HCA-contracted vendor providing PEBB insurance coverage on behalf of HCA, its employees, or other persons

If a retiree's PEBB insurance coverage is terminated by HCA for the above reasons, PEBB insurance coverage for all of the retiree's eligible dependents is also terminated.

The PEBB Program will enroll an employee and their eligible dependents in another PEBB vision plan upon termination from this plan.

ELIGIBILITY PROVISIONS: INSURANCE FOR THE SUBSCRIBER AND THE SUBSCRIBER'S DEPENDENTS (continued)

Appeal rights

Any current or former employee of a State Agency or their dependent may appeal a decision made by the State Agency regarding PEBB eligibility, enrollment, or premium surcharges to the State Agency.

Any current or former employee of an Employer Group, such as a county, city, port, water district, etc., that contracts with HCA for PEBB benefits, or their dependent may appeal a decision made by an Employer Group regarding PEBB eligibility, enrollment, or premium surcharges to the Employer Group.

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

Any Enrollee may appeal a decision regarding the administration of a PEBB vision plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment decisions.

Learn more at hca.wa.gov/pebb-appeals.

Relationship to law and regulations

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

VISION INSURANCE

Benefits are available for Covered Services and Materials provided by either In-Network Vision Providers or Out-of-Network Vision Providers. However, Members may be able to reduce out-of-pocket costs by using In-Network Vision Providers because Out-of-Network Vision Providers have not entered into an agreement to limit their charges. Members are always free to receive services from any Vision Provider. Members do not need any authorization from Us before seeing a Vision Provider.

In-Network Vision Providers have agreed to provide Covered Services and Materials as listed in the SCHEDULE OF BENEFITS.

If a Member incurs a charge for Covered Services and Materials from an Out-of-Network Vision Provider, Proof of such service must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the insurance in effect on the date that service was completed.

The benefits available under this Vision Insurance are set forth on the SCHEDULE OF BENEFITS. In addition to the Co-Payment, if applicable, Members may be responsible for:

- the cost of any services or materials that are not Covered Services and Materials; and
- the cost of any service or material that is in excess of the Maximum Benefit Allowance listed on the SCHEDULE OF BENEFITS.

We do not provide vision services. Whether or not benefits are available for a particular service does not mean Members should or should not receive the service. The Member and their Vision Provider have the right and are responsible at all times for choosing the course of treatment and services to be performed.

When requesting Covered Services and Materials from an In-Network Vision Provider, We recommend that Members confirm that the Vision Provider is currently an In-Network Vision Provider at the time that the Covered Services and Materials are provided.

Members can obtain a customized listing of MetLife's In-Network Vision Providers either by calling 1-866-548-7139 or by visiting Our website at www.mybenefits.metlife.com/wahca.

PLAN BENEFITS

We will pay benefits for charges incurred by a Member for Covered Services and Materials as shown in the SCHEDULE OF BENEFITS, subject to the conditions set forth in this certificate.

If a Member receives Covered Services and Materials from an In-Network Vision Provider, We will pay the provider directly for all covered benefits.

If a Member receives Covered Services and Materials from an Out-of-Network Vision Provider, and the Subscriber assigns payment of Vision Insurance benefits to a Member's Vision Provider, We will pay benefits directly to the Vision Provider. Otherwise, We will pay Vision Insurance benefits to the Subscriber.

In-Network

If Covered Services and Materials are provided by an In-Network Vision Provider, We will base the benefit on the Plan Benefits listed on the SCHEDULE OF BENEFITS.

If an In-Network Vision Provider provides Covered Services and Materials, Members will be responsible for paying:

- the Co-Payment, if applicable; and
- the cost of any service or material that is in excess of the Plan Benefits listed on the SCHEDULE OF BENEFITS.

VISION INSURANCE (continued)

Out-of-Network

If Covered Services and Materials are provided by an Out-of-Network Vision Provider, We will base the benefit on the Plan Benefits listed on the SCHEDULE OF BENEFITS, subject to the Maximum Benefit Allowance.

Out-of-Network Vision Providers may charge Members more than the Maximum Benefit Allowance. If an Out-of-Network Vision Provider provides Covered Services and Materials, Members will be responsible for paying any amount in excess of the Maximum Benefit Allowance charged by the Out-of-Network Vision Provider.

Visually Necessary Contact Lenses

A visually necessary contact lens exam and an annual supply of visually necessary contact lenses are covered in full for patients meeting the established conditions below. Those patients must be eligible for materials on the date of service. Coverage is limited and may require special handling to ensure proper reimbursement. Exam and material (prescription lenses and frame) copays for contact lenses apply unless otherwise specified.

Note: Visually necessary contact lenses aren't typically covered for patients who have received refractive surgery (e.g., LASIK, PRK, or RK). However, patients with underlying conditions such as corneal ectasia, corneal deformity, scarring or irregularity that require contact lenses to provide vision improvement, may be covered for visually necessary contact lenses, if they meet the approved criteria. Treatment for corneal abrasion is covered under Essential Medical Eye Care.

Benefit Coverage Criteria for Base Lenses

- Nystagmus – H55.00 through H55.09, H81.10 through H81.23, or H81.41 through H81.49
- Anisometropia greater than or equal to 3.00 diopters difference based on the spectacle prescription.
- High ametropia greater than or equal to ±10.00 diopters in either eye based on the spectacle prescription.
- Please see Visually Necessary Contact Lens Specialty Contact Lenses below for a complete listing of covered diagnosis codes.

Colored contact lenses (for Visually Necessary Contacts) are a covered benefit for patients with the following conditions:

- Achromatopsia – H53.51
- Albinism – E70.30, E70.310, E70.311, E70.318, E70.319
- Aniridia – Q13.1
- Polycoria; anisocoria (congenital) – Q13.0
- Pupillary abnormalities – H21.561 through H21.569

To submit visually necessary contact lens claims through eClaim for any of the conditions above, the Vision Provider must do the following:

Select Necessary Contact Lens as the Contact Lens Reason. Indicate the appropriate diagnosis code and/or spectacle prescription verifying the condition. For anisometropia and/or high ametropia, enter the spectacle prescription on the lab invoice for verification purposes.

Scleral Lenses (For Covered Contacts and Visually Necessary Contacts)

Bill scleral lenses using HCPCS V2530 or V2531. Hybrid contact lenses are not scleral lenses and will not be reimbursed as sclerals. Bill hybrid lenses using V2599.

When submitting a claim for Visually Necessary Contacts using V2531, the Vision Provider must provide the following information in Box 19:

- Type of lens – Scleral
- The scleral lens manufacturer or brand

If this information is missing or incomplete, it will result in claim reimbursement at the V2599 rate.

Other Type of Contact Lenses (For Covered Contacts and Visually Necessary Contacts)

Use HCPCS code V2599 for other types of contact lenses, such as hybrid lenses.

When submitting a claim using V2599 (contact lens, other type) the Vision Provider must provide the following information in Box 19:

- Type of lens
- The lens manufacturer or brand
- For example, hybrid contact lens, SynergEyes® iD

Note: Bill scleral lenses using HCPCS V2530 or V2531. Hybrid contact lenses are not scleral lenses and will not be reimbursed as scleral.

Piggyback Lenses Benefit

Piggyback lenses are a covered benefit for patients meeting one of the conditions above, and who aren't able to tolerate rigid gas permeable contact lenses. This requires the use of soft contact lenses and rigid gas permeable contact lenses, in the manner of a piggyback fitting.

When submitting a claim for piggyback lenses, the Vision Provider must provide the following information in Box 19:

- Piggyback lenses

Spectacle lenses to wear over contacts benefit

Contacts with spectacle lenses to wear over contacts are covered benefits for patients with the following conditions:

- Aphakia – H27.00 - H27.03 or Q12.3
- High ametropia greater than or equal to ±10.00 diopters in either eye based on the spectacle
- prescription.
- Presbyopia – H52.4
- Pseudophakia – Z96.1
- Accommodative disorder
- Binocular function disorder
- Different prism requirements for distance and near vision

A prescription is required for the lenses. Plano lenses aren't a covered benefit.

When your patient qualifies for spectacle lenses to be worn over contact lenses, request the spectacle lenses claim number at the same time or within 30 days of the contact lens claim submission date. For patients with keratoconus, request a claim number for spectacle lenses to be worn over contact lenses within 12 months of the contact lens claim submission date. Frames are private transaction between you and your patient.

If your patient meets the benefit criteria for visually necessary contact lenses above and also requires spectacle lenses to wear over the contacts, please verify that the above criteria is met, and call VSP at 800.615.1883 to obtain a claim number. Please have the relevant criteria information available when calling.

Submitting Claims

Vision Providers should request a case number when your patient meets the benefit coverage criteria above, but you can't submit your claim through eClaim at eyefinity.com. To get a case number so you can submit your claim through eClaim, complete a Materials Verification Form, which must include at least one of the qualifying criteria listed above. Please allow five (5) business days for a response. Put your case number in Box 23.

VISION INSURANCE (continued)

The following situations also require the submittal of a Materials Verification Form:

- NCL claims with DOS over 6 months
- Physical condition of ears or nose which prohibits the use of eyeglasses
- Physical symptoms associated with paraplegia or quadriplegia (be specific)

Fax the Materials Verification Form to us at 916.851.4733. Or mail to VSP, PO Box 385020, Birmingham, AL 35238-5020. You can find the form in the VSPOnline section of eyefinity.com or in the Tools and Forms section Of this manual.

Visually Necessary Specialty Contact Lenses
If billing with CPT code 92072*, 92311*, 92312* or 92313* – for one of these diagnosis codes:

*Codes may not be billed together on the same claim.

Description	ICD-10 Codes:
Absence of iris (Aniridia)	Q13.1
Achromatopsia	H53.51
Adherent leukoma	H17.00 - H17.03
Albinism	E70.30
Aphakia	H27.00 - H27.03
Band keratopathy	H18.421- H18.429
Breakdown (mechanical) of other ocular prosthetic devices, implants and grafts	T85.318A - T85.318S
Bullous keratopathy	H18.10 - H18.13
Central corneal opacity	H17.10 - H17.13
Coloboma of iris	Q13.0
Congenital aphakia	Q12.3
Congenital corneal opacity	Q13.3
Corneal ectasia	H18.711 - H18.719
Corneal scars and opacities	H17.00 - H17.9, A18.59
Corneal staphyloma	H18.721 - H18.729
Corneal transplant failure	T86.8411 - T86.8419
Corneal transplant rejection	T86.8401 - T86.8409
Corneal transplant status	Z94.7
Corrosion of cornea and conjunctival sac	T26.60XA - T26.62XS
Deep vascularization of cornea	H16.441 - H16.449
Displacement of other ocular prosthetic devices, implants and grafts	T85.328A - T85.328S
Endothelial corneal dystrophy	H18.511 - H18.519
Enophthalmos due to atrophy of orbital tissue	H05.419
Epithelial (juvenile) corneal dystrophy	H18.521– H18.529

Folds and rupture in Bowman's membrane	H18.311 - H18.319
Graft-versus-host disease	D89.813
Granular corneal dystrophy	H18.531 – H18.539
Keratoconus, stable	H18.611 - H18.619
Keratoconus, unspecified	H18.601 - H18.629
Keratoconus, unstable	H18.621 - H18.629
Keratoconjunctivitis sicca, in Sjogren's syndrome	M35.01
Keratomalacia	H18.441 - H18.449
Lattice corneal dystrophy	H18.541 - H18.549
Localized vascularization of cornea Covered for significant cases only where corneal neovascularization is a complication of inflammatory, infectious or autoimmune corneal pathologies	H16.431 - H16.439
Macular corneal dystrophy	H18.551 - H18.559
Minor opacity of cornea	H17.811 - H17.819
Nodular corneal degeneration	H18.451 - H18.459
Ocular laceration and rupture with prolapse or loss of intraocular tissue	S05.20XA - S05.22XS
Ocular laceration without prolapse or loss of intraocular tissue	S05.30XA - S05.32XS
Other calcerous corneal degeneration	H18.43
Other congenital corneal malformations	Q13.4
Other corneal degeneration	H18.49
Other corneal scars and opacities	H17.89
Other hereditary corneal dystrophies	H18.591 – H18.599
Other injuries of eye and orbit	S05.8X1A - S05.8X9S
Other keratitis	H16.8
Other mechanical complication of other ocular prosthetic devices, implants and grafts	T85.398A - T85.398S
Other tuberculosis of eye	A18.59
Penetrating wound with foreign body	S05.50XA - S05.52XS
Peripheral corneal degeneration Covered for marginal corneal degenerations, such as pellucid and Terrien, or as a result of previous ocular disease or trauma	H18.461 - H18.469
Peripheral opacity of cornea	H17.821 - H17.829
Pupillary abnormality	H21.561 - H21.569

Recurrent erosion of cornea	H18.831 - H18.839
Unspecified corneal deformity	H18.70
Unspecified corneal degeneration	H18.40
Unspecified corneal membrane change	H18.30
Unspecified corneal scar and opacity	H17.9
Unspecified hereditary corneal dystrophies	H18.501 - H18.509
Unspecified injury of unspecified eye and orbit	S05.90XA - S05.92XS
Vitamin A deficiency with xerophthalmic scars of cornea	E50.6

Note: To substantiate billing for keratoconus, records must include: patient history; K readings; BCVA with refraction; slit lamp examination of the cornea; corneal topography or anterior OCT of the cornea.

The codes listed above are from the International Classification of Diseases, Ninth Revision, Clinical Modification and are used to describe diseases, injuries, symptoms and conditions. If the Member has questions about the diagnoses listed above or the codes included with the diagnoses, please contact the Member's Vision Provider.

VISION INSURANCE: DESCRIPTION OF COVERED SERVICES AND MATERIALS

Subject to the Service Intervals and Plan Benefits indicated in the SCHEDULE OF BENEFITS, the following will be Covered Services and Materials:

1. One complete visual examination.

2. Standard corrective lenses. We will cover a pair of standard single vision, lined bifocal, lined trifocal or lenticular lenses that are necessary to correct vision. Standard corrective lenses are as follows:

    - eye sizes up to and including 60mm;
    - multi-focal lenses in all segment widths;
    - prism and slab off;
    - base curves (regardless of curve);
    - lenses with the combined power in any meridian is +/- .50 diopters or greater in at least one eye; and
    - plastic or glass lenses.

3. The following lens options described in the SCHEDULE OF BENEFITS: tint (solid and gradient), standard plastic scratch coating, standard polycarbonate (if you are less than 18 years of age, standard anti-reflective coating, plastic photochromic, polarized premium anti-reflective.

4. Contact lenses.

    - A standard fitting and 1 follow-up visit by a Vision Provider.
    - The following contact lenses options, as described in the SCHEDULE OF BENEFITS: conventional, disposable, and Necessary.

5. Necessary low vision aids.

6. We do not cover costs above the Maximum Benefit Allowance shown in the SCHEDULE OF BENEFITS for frames. If frames are selected that are more expensive than that amount, the Member will be charged the difference between the Maximum Benefit Allowance and the Vision Provider's charge for the more expensive frame.

7. Necessary contact lenses in lieu of all benefits for vision materials.

VISION INSURANCE: EXCLUSIONS

We will not pay Vision Insurance benefits for charges incurred for:

1. Services and/or materials not specifically included in the SCHEDULE OF BENEFITS as covered Plan Benefits.
2. Any portion of a charge in excess of the Maximum Benefit Allowance or reimbursement indicated in the SCHEDULE OF BENEFITS.
3. Plano lenses (lenses with refractive correction of less than ± .50 diopter).
4. Two pairs of glasses instead of bifocals.
5. Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost, stolen or damaged, except at the normal Service Intervals when Plan Benefits are otherwise available.
6. Orthoptics or vision training and any associated supplemental testing.
7. Medical or surgical treatment of the eye.
8. Prescription or non-prescription medications.
9. Contact lens insurance policies and service agreements.
10. Refitting of contact lenses after the initial (90-day) fitting period.
11. Contact lens modification, polishing and cleaning.
12. Any eye examination or any corrective eyewear required as a condition of employment.
13. Services or supplies received by a Member before the Vision Insurance starts for that person.
14. Missed appointments.
15. Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. The Subscriber must promptly claim and notify the Company of all such benefits.
16. Local, state and/or federal taxes, except where MetLife is required by law to pay.
17. Services:
    - for which the employer of the person receiving such services is required to pay by law; or
    - received at a facility maintained by the employer, labor union, mutual benefit association, or VA hospital.
18. Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
19. Services, procedures, or materials for which a charge would not have been made in the absence of insurance.

VISION INSURANCE: COORDINATION OF BENEFITS

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

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan.** The **Primary plan** must pay benefits according to its policy terms without regard to the possibility that another **Plan** may cover some expenses. 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.**

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for 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. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

(1) **Plan** includes: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) 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** means, in a **COB** provision, the part of the contract providing the vision 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 vision 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. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has vision 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 must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the **Total Allowable expense** for that claim. This means that when this **Plan** is **Secondary,** it must pay the amount which, when combined with what the **Primary plan** paid, totals 100% of the highest **Allowable expense.** In addition, if this **Plan** is **Secondary,** it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the **Primary plan**) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an **Allowable expense** under this **Plan.** If this **Plan** is **Secondary**, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

D. **Allowable expense** is a vision care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense.**

The following are examples of expenses that are not **Allowable expenses:**

(1) If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense.**

(2) 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.**

(3) 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. **Closed panel plan** is a **Plan** that provides vision benefits to covered persons in the form of services through a panel of providers who are primarily employed by the **Plan,** and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **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.

ORDER OF BENEFIT DETERMINATION RULES

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

(2) 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 is excess to any other parts of the **Plan** provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

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

D. 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 Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one **Plan** the order of benefits is determined as follows:

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

• The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan;** or

• If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan.**

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

(i) If a court decree states that one of the parents is responsible for the Dependent child's vision care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to claim determination periods commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

(iii) If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;

(iv) If a court decree 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 subsection (a) above determine the order of benefits; or

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

• The **Plan** covering the **Custodial parent,** first;

• The **Plan** covering the spouse of the **Custodial parent,** second;

• The **Plan** covering the **non-custodial parent,** third; and then

• The **Plan** covering the spouse of the **non-custodial parent,** last

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

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

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan,** the **Plan** covering the person as an employee, member, Subscriber or retiree or covering the person as a Dependent of an employee, member, Subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan.** If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, Subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan.**

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

RIGHT TO RECEIVE AND RELEASE NEEDED 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 may get the facts from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Us any facts needed to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

If payments that should have been made under **This plan** are made by another **Plan,** the issuer has the right, at its discretion, to remit to the other **Plan** the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other **Plan** are considered benefits paid under **This plan.** To the extent of such payments, the issuer is fully discharged from liability under **This plan.**

RIGHT OF RECOVERY

We have the right to recover excess payment whenever We have paid Allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

If the Member has Questions about Coordination of Benefits, please contact MetLife at 1-866-548-7139.

If the Member is covered by more than one vision benefit plan, and the Member does not know which is the Member's primary plan, the Member's vision provider should contact any one of the vision plans to verify which plan is primary. The health plan the Member contact is responsible for working with the other plan to determine which is primary and will let the Member know within thirty calendar days.

VISION INSURANCE: COORDINATION OF BENEFITS (continued)

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

To avoid delays in claims processing, if the Member is covered by more than one plan the Member should promptly report to the Member’s vision providers and plans any changes in the Member’s coverage."

VISION INSURANCE: FILING A CLAIM

CLAIMS FOR VISION INSURANCE

If you select an In Network Vision Provider, the Member does not need to file a claim.

If you select an Out-of-Network Vision Provider, the Member may provide full payment to the Out-of-Network Vision Provider at the time of service and submit the invoice including an itemized statement of charges with the Member's claim form, or the Member may be able to assign the claim to the Out-of-Network Vision Provider. If the Out-of-Network Vision Provider accepts the assignment, the provider will submit the claim on your behalf. The Member will be responsible for any charges not covered by the Plan.

Out of network claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-866-548-7139. Vision claim forms can also be downloaded from www.metlife.com/mybenefits. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

When We receive the claim form and Proof, the Member claim will be paid subject to the terms and provisions of this certificate and the Group Policy.

CLAIMS FOR VISION INSURANCE BENEFITS

When a claimant files a claim for Vision Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 180 days from the date of service. If it was not reasonably possible to give Written Proof within 180 days from the date of service, We will not reduce or deny the claim for this reason if the Proof is filed as soon as reasonably possible.

Claim and Proof may be given to Us by following the steps set forth below:

Step 1
A claimant can request a claim form by downloading it from www.metlife.com/mybenefits.

Step 2
Complete the claim form as instructed and return it with the invoice.

Step 3
The claimant must give Us Proof not later than one(1) year from the date of service unless the claimant is legally incapacitated. In any event, the Proof required must be given no later than one (1) year from the time specified.

We will pay the claim as soon as We receive proper Written Proof of loss.

Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-866-548-7139.

Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

Initial Appeal. All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

VISION INSURANCE: FILING A CLAIM (continued)

Second Level Appeal. If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

Other Remedies. When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

Time of Action. No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, from the time Written Proof of Loss is required to be given.

Insurance Fraud: Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

Upon receipt of a Covered Service, the Member may assign Vision Insurance benefits to the Vision Provider providing such service.

Vision Insurance: Who We Will Pay

If the Member assigns payment of Vision Insurance benefits to the Member's Vision Provider, We will pay benefits directly to the Vision Provider. Otherwise, We will pay Vision Insurance benefits to the Member.

Entire Contract

The Member’s insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

If there is a conflict in language between the Group Policy and the certificate, the certificate governs.

Incontestability: Statements Made by the Member

Any statement made by the Member will be considered a representation and not a warranty.

Evidence of insurability will not be required nor will any statement made by the Member, which relates to insurability, be used:

1. to contest the validity of the insurance benefits; or
2. to reduce the insurance benefits.

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.1

THIS IS THE END OF THE CERTIFICATE.

THE FOLLOWING IS ADDITIONAL INFORMATION.

Delaware American Life Insurance Company
MetLife Health Plans, Inc.
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
Metropolitan General Insurance Company
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, as an executive benefit, or as otherwise made available at your work or through an association to which you belong. In this notice "you" refers to these individuals.

SECTION 2: Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

SECTION 3: Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life insurers, a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

SECTION 4: How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB, LLC ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB, LLC, 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

SECTION 6: Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

SECTION 7: HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. We will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

SECTION 9: Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

HIPAA Notice of Privacy Practices for Protected Health Information

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.

Dear MetLife Customer:

This is your Health Information Privacy Notice from Metropolitan Life Insurance Company or a member of the MetLife, Inc. family of companies, which includes SafeGuard Health Plans, Inc., SafeHealth Life Insurance Company, and Delaware American Life Insurance Company (collectively, "**MetLife**"). **Please read it carefully.** You have received this notice because of your Dental, Vision, Long-Term Care, Cancer and Specified Disease Expense Insurance, or Health coverage with us (your "**Coverage**"). MetLife strongly believes in protecting the confidentiality and security of information we collect about you. This notice refers to MetLife by using the terms "us," "we," or "our."

This notice describes how we protect the personal health information we have about you which relates to your MetLife Coverage ("**Protected Health Information**" or "**PHI**"), and how we may use and disclose this information. PHI includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also describes your rights with respect to the PHI and how you can exercise those rights.

We are required to provide this notice to you by the Health Insurance Portability and Accountability Act ("**HIPAA**"). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please see the privacy notices contained at our website,**www.metlife.com**. You may submit questions to us there or you may write to us directly at MetLife, Americas – U.S. HIPAA Privacy Office, P.O. Box 902, New York, NY 10159-0902.

NOTICE SUMMARY

The following is a brief summary of the topics covered in this HIPAA notice. Please refer to the full notice below for details.

As allowed by law, we may **use** and **disclose** PHI to:

- make, receive, or collect payments;
- conduct health care operations;
- administer benefits by sharing PHI with affiliates and Business Associates;
- assist plan sponsors in administering their plans; and
- inform persons who may be involved in or paying for another's health care.

In addition, we may use or disclose PHI:

- where required by law or for public health activities;
- to avert a serious threat to health or safety;
- for health-related benefits or services;
- for law enforcement or specific government functions;
- when requested as part of a regulatory or legal proceeding; and
- to provide information about deceased persons to coroners, medical examiners, or funeral directors.

You have the right to:

- receive a copy of this notice;
- inspect and copy your PHI, or receive a copy of your PHI;
- amend your PHI if you believe the information is incorrect;
- obtain a list of disclosures we made about you (except for treatment, payment, or health care operations);

- ask us to restrict the information we share for treatment, payment, or health care operations;
- request that we communicate with you in a confidential manner; and
- complain to us or the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

We are required by law to:

- maintain the privacy of PHI;
- provide this notice of our legal duties and privacy practices with respect to PHI;
- notify affected individuals following a breach of unsecured PHI; and
- follow the terms of this notice.

NOTICE DETAILS

We protect your PHI from inappropriate use or disclosure. Our employees, and those of companies that help us service your MetLife Coverage, are required to comply with our requirements that protect the confidentiality of PHI. They may look at your PHI only when there is an appropriate reason to do so, such as to administer our products or services.

Except in the case of Long-Term Care Coverage, we will **not use or disclose** PHI that is genetic information for underwriting purposes. For example, we will not use information from a genetic test (such as DNA or RNA analysis) of an individual or an individual's family members to determine eligibility, premiums or contribution amounts under your Coverage.

We will **not sell or disclose** your PHI to any other company for their use in marketing their products to you. However, as described below, we will use and disclose PHI about you for business purposes relating to your Coverage.

The main reasons we may **use** and **disclose** your PHI are to evaluate and process any requests for coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you. The following describe these and other uses and disclosures.

- For Health Care Operations: We may also use and disclose PHI for our insurance operations. These purposes include evaluating a request for our products or services, administering those products or services, and processing transactions requested by you.

- To Affiliates and Business Associates: We may disclose PHI to Affiliates and to business associates outside of the MetLife family of companies if they need to receive PHI to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of PHI. Examples of business associates are: billing companies, data processing companies, companies that provide general administrative services, health Information organizations e-prescribing gateways, or personal health record vendors that provide services to covered entities. PHI may be disclosed to reinsurers for underwriting, audit or claim review reasons. PHI may also be disclosed as part of a potential merger or acquisition involving our business in order that the parties to the transaction may make an informed business decision.

- To Plan Sponsors: We may disclose summary health information such as claims history or claims expenses to a plan sponsor to enable it to obtain premium bids from health plans, or to modify, amend or terminate a group health plan. We may also disclose PHI to a plan sponsor to help administer its plan if the plan sponsor agrees to restrict its use and disclosure of PHI in accordance with federal law.

- To Individuals Involved in Your Care: We may disclose your PHI to a family member or other individual who is involved in your health care or payment of your health care. For example, we may disclose PHI to a covered family member whom you have authorized to contact us regarding payment of a claim.

- Where Required by Law or for Public Health Activities: We disclose PHI when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing PHI to a governmental agency or regulator with health care oversight responsibilities.

- To Avert a Serious Threat to Health or Safety: We may disclose PHI to avert a serious threat to someone's health or safety. We may also disclose PHI to federal, state or local agencies engaged in disaster relief, as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

For Payment: We may use and disclose PHI to pay benefits under your Coverage. For example, we may review PHI contained in claims to reimburse providers for services rendered. We may also disclose PHI to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose PHI to a health plan or an administrator of an employee welfare benefit plan for various payment-related functions, such as eligibility determination, audit and review, or to assist you with your inquiries or disputes.
interest to you. However, we will not send marketing communications to you in exchange for financial remuneration from a third party without your authorization.

- **For Law Enforcement or Specific Government Functions:** We may disclose PHI in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose PHI about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **When Requested as Part of a Regulatory or Legal Proceeding:** If you or your estate are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the PHI requested. We may disclose PHI to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

- **PHI about Deceased Individuals :** We may release PHI to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death. In addition, we may disclose a deceased's person's PHI to a family member or individual involved in the care or payment for care of the deceased person unless doing so is inconsistent with any prior expressed preference of the deceased person which is known to us.

- **Other Uses of PHI:** Other uses and disclosures of PHI not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose PHI about you, you or your legally authorized representative may revoke that authorization in writing at any time, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.

- For Health-Related Benefits or Services: We may use your PHI to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about health-related products or services that may be of of the PHI that we maintain about you. If we maintain the requested PHI electronically, you may ask us to provide you with the PHI in electronic format, if readily producible; or, if not, in a readable electronic form and format agreed to by you and us. To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing, electronic media, or other supplies associated with your request. You may also direct us to send the PHI you have requested to another person designated by you, so long as your request is in writing and clearly identifies the designated individual. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI collected by us in connection with, or in reasonable anticipation of, any claim or legal proceeding. In very limited circumstances, we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

- **Right to Amend Your PHI:** If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must specify the reason for your request. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that:

- is accurate and complete;
- was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;
- is not part of the PHI kept by or for us; or
- is not part of the PHI which you would be permitted to inspect and copy.

- **Right to a List of Disclosures:** You have the right to request a list of the disclosures we have made of your PHI. This list will not include disclosures made for treatment, payment, health care operations, purposes of national security, to law enforcement, to corrections personnel, pursuant to your authorization, or directly to you. To request this list, you must submit your request in writing. Your request must state the time period for which you want to receive a list of disclosures. You may only request an accounting of disclosures for a period of time less than six years prior to the date of your request. Your request should indicate in what form you want the

Your Rights Regarding Protected Health Information That We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your PHI. Should you have questions about or wish to exercise a specific right, please contact us in writing at the applicable Contact Address listed on the last page.

Right to Inspect and Copy Your PHI: In most cases, you have the right to inspect and obtain a copy Use or disclose about you for treatment, payment, or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, **we are not required to agree to it.** If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.

- **Right to Request Confidential Communications :** You have the right to request that we communicate with you about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Contact Addresses:** If you have any questions about a specific individual right or you want to exercise one of your individual rights, please submit your request in writing to the address below which applies to your Coverage:

MetLife or SafeGuard Dental & Vision
P.O. Box 14587
Lexington, KY 40512-4587

MetLife LTC Privacy Coordinator
1300 Hall Boulevard, 3rd Floor
Bloomfield, CT 06002

Delaware American Life Insurance Company
MetLife Worldwide Benefits
P.O. Box 1449
Wilmington, DE 19899-1449

list (for example, paper or electronic). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any cost.

- **Right to Request Restrictions:** You have the Right to request a restriction or limitation on PHI we of the PHI that we maintain about you. If we maintain the requested PHI electronically, you may ask us to provide you with the PHI in electronic format, if readily producible; or, if not, in a readable electronic form and format agreed to by you and us. To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing, electronic media, or other supplies associated with your request. You may also direct us to send the PHI you have requested to another person designated by you, so long as your request is in writing and clearly identifies the designated individual. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI collected by us in connection with, or in reasonable anticipation of, any claim or legal proceeding. In very limited circumstances, we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

- **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact MetLife, Americas – U.S. HIPAA Privacy Office, P.O. Box 902, New York, NY 10159-0902. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions as to how to file a complaint, please contact us at telephone number (212) 578-0299 or at HIPAAprivacyAmericasUS@metlife.com.

ADDITIONAL INFORMATION

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for PHI we already have about you, as well as any PHI we receive in the future. The effective date of this notice and any revised or changed notice may be found on the last page, on the bottom right-hand corner of the notice. You will receive a copy of any revised notice from MetLife by mail or by e-mail, if e-mail delivery is offered by MetLife and you agree to such delivery.

Cancer and Specified Disease Expense Insurance
c/o Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716

Further Information: You may have additional rights under other applicable laws. For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please e-mail us at HIPAAprivacyAmericasUS@metlife.com or call us at telephone number (212) 578-0299, or write us at:

MetLife, Americas
U.S. HIPAA Privacy Office
P.O. Box 902
New York, NY 10159-0902

Effective Date: 10312024

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Uniformed Services Employment And Reemployment Rights Act

This section describes the right that you may have to continue coverage for yourself and your covered dependents under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation of Group Vision Insurance:

If you take a leave from employment for "service in the uniformed services," as that term is defined in USERRA, and as a consequence your vision insurance coverage under your employer's group vision insurance policy ends, you may elect to continue vision insurance for yourself and your covered dependents, for a limited period of time, as described below.

The law requires that your employer notify you of your rights, benefits and obligations under USERRA including instructions on how to elect to continue insurance, the amount and procedure for payment of premium. If permitted by USERRA, your employer may require that you elect to continue coverage within a period of time specified by your employer.

You may be responsible for payment of the required premium to continue insurance. If your leave from employment for service in the uniformed services lasts less than 31 days, your required premium will be no more than the amount you were required to pay for vision insurance before the leave began; for a leave lasting 31 or more days, you may be required to pay up to 102% of the total vision insurance premium, including any amount that your employer was paying before the leave began.

Your and your covered dependents' insurance that is continued pursuant to USERRA will end on the earliest of the following:

- the end of 24 consecutive months from the date your leave from employment for service in the uniformed services begins; or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You and your covered dependent may become entitled to continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") while you have vision insurance coverage under your employer's group vision insurance policy pursuant to USERRA. Contact your employer for more information.

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

For Idaho Residents: TEN DAY RIGHT TO EXAMINE CERTIFICATE: You may return the certificate to Us within 10 days from the date You receive it. If You return it within the 10 day period, the certificate will be considered never to have been issued. We will refund any premium paid after We receive Your notice of cancellation.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

For New Mexico Residents: This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that the Subscriber have health insurance coverage. If the Subscriber does not have other health insurance coverage, the Subscriber may be subject to a federal tax penalty.

For New Mexico Residents: If You are not satisfied with Your certificate for any reason, You may return it to Us within 30 days after You receive it, unless a claim has previously been received by Us under Your certificate. We will refund any premium that has been paid and the certificate will then be considered to have never been issued. You should be aware that, if You elect to return the certificate for a refund of premiums, losses which otherwise would have been covered under Your certificate will not be covered.

For New Hampshire Residents: 30 Day Right to Examine Certificate.
Please read this Certificate. The Subscriber may return the Certificate to Us within 30 days from the date the Subscriber receive it. If you return it within the 30 day period, the Certificate will be considered never to have been issued and We will refund any premium paid for insurance under this Certificate.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

NOTICE FOR RESIDENTS OF TEXAS

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Metropolitan Life Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Corporate Consumer Relations Department at 1-800-438-6388

Toll-free: 1-800-438-6388

Email: Johnstown_Complaint_Referrals@metlife.com

Mail: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

NOTICE FOR RESIDENTS OF TEXAS

Metropolitan Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388

Teléfono gratuito: 1-800-438-6388

Correo electrónico: Johnstown_Complaint_Referrals@metlife.com

Dirección postal: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

NOTICE FOR RESIDENTS OF ALASKA, CONNECTICUT, LOUISIANA, MINNESOTA, MONTANA, NEW HAMPSHIRE, NEW MEXICO, TEXAS AND UTAH

The Definition Of Child Is Modified For The Coverages Listed Below:

For Alaska Residents (Vision Insurance):

The term also includes newborns.

For Connecticut Residents (Vision Insurance):

The age limit for children will not be less than 26, regardless of the child's marital status, student status or full- time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

A Child's insurance will not end due to age until the end of the Year in which that Child attains age 26.

For Louisiana Residents (Vision Insurance):

The term also includes the Subscriber's grandchildren residing with the Subscriber. The age limit for children and grandchildren will not be less than 21, regardless of the child's or grandchild's student status or full-time employment status. In addition, the age limit for students will not be less than 24. The Subscriber's natural child, adopted child, stepchild or grandchild under age 21 will not need to be supported by the Subscriber to qualify as a Child under this insurance.

For Minnesota Residents (Vision Insurance):

The term also includes:

- the Subscriber's grandchildren who are financially dependent upon the Subscriber and reside with the Subscriber continuously from birth;
- children for whom the Subscriber, the Subscriber's Spouse or State-Registered Domestic Partner is the legally appointed guardian; and
- children for whom the Subscriber have initiated an application for adoption.

The age limit for children and grandchildren will not be less than 25 regardless of the child's or grandchild's student status or full-time employment status. The Subscriber's natural child, adopted child stepchild or children for whom the Subscriber or the Subscriber's Spouse or State-Registered Domestic Partner is the legally appointed guardian under age 25 will not need to be supported by the Subscriber to qualify as a Child under this insurance.

For Montana Residents (Vision Insurance):
The term also includes newborn infants of any person insured under this certificate. The age limit for children will not be less than 25, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a child under this insurance.

For New Hampshire Residents (Vision Insurance):

The age limit for children will not be less than 26, regardless of the child's marital status, student status or full-time employment status. The Subscriber's natural child, adopted child or stepchild under age 26 will not need to be supported by the Subscriber to qualify as a Child under this insurance.

NOTICE FOR RESIDENTS OF ALASKA, CONNECTICUT, LOUISIANA, MINNESOTA, MONTANA, NEW HAMPSHIRE, NEW MEXICO, TEXAS AND UTAH (continued)

For New Mexico Residents (Vision Insurance):

The age limit for children will not be less than 25, regardless of the child's student status or full-time employment status. The Subscriber's natural child, adopted child or stepchild will not be denied vision insurance coverage under this certificate because:

- that child was born out of wedlock;
- that child is not claimed as the Subscriber's dependent on the Subscriber's federal income tax return; or
- that child does not reside with the Subscriber.

For Texas Residents (Vision Insurance):

The term also includes the Subscriber's grandchildren. The age limit for children and grandchildren will not be less than 25, regardless of the child's or grandchild's student status, full-time employment status or military service status. The Subscriber's natural child, adopted child or stepchild under age 25 will not need to be supported by the Subscriber to qualify as a Child under this insurance. In addition, grandchildren must be able to be claimed by the Subscriber as a dependent for Federal Income Tax purposes at the time the Subscriber applied for Insurance.

For Utah Residents (Vision Insurance):

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. The Subscriber's natural child, adopted child or stepchild under age 26 will not need to be supported by the Subscriber to qualify as a Child under this insurance. The term includes an unmarried child who is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law and who has been continuously covered under a Vision plan since reaching age 26, with no break in coverage of more than 63 days, and who otherwise qualifies as a Child except for the age limit. Proof of such handicap must be sent to Us within 31 days after:

- the date the Child attains the limiting age in order to continue coverage; or
- the Subscriber enrolls a Child to be covered under this provision;

and at reasonable intervals after such date, but no more often than annually after the two-year period immediately following the date the Child qualifies for coverage under this provision.

NOTICE FOR RESIDENTS OF ARKANSAS

If the Subscriber have a question concerning the Subscriber's coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, the Subscriber still has a concern, the Subscriber may call the toll free telephone number shown on the Certificate Face Page.

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). The Subscriber may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
ATTN: CONSUMER RELATIONS DEPARTMENT
500 SCHOOLHOUSE ROAD
JOHNSTOWN, PA 15904

1-800-438-6388

IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA DEPARTMENT OF INSURANCE AT:

DEPARTMENT OF INSURANCE
CONSUMER SERVICES
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013

WEBSITE: http://www.insurance.ca.gov/

1-800-927-4357 (within California)
1-213-897-8921 (outside California)

NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

California law provides that for vision insurance, domestic partners of California's residents must be treated the same as spouses. If the certificate does not already have a definition of domestic partner, then the following definition applies:

> **"Domestic Partner** means each of two people, one of whom is an employee of the Policyholder, a resident of California and who have registered as domestic partners or members of a civil union with the California government or another government recognized by California as having similar requirements."

If the certificate already has a definition of domestic partner, that definition will apply to California residents, as long as it recognizes as a domestic partner any person registered as the employee's domestic partner with the California government or another government recognized by California as having similar requirements.

Wherever the term **"Spouse"** appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Wherever the term step-child appears, it is replaced by step-child or child of Your Domestic Partner.

NOTICE FOR RESIDENTS OF CONNECTICUT

If You are a resident of Connecticut, and live in a county where there is no In-Network Vision Provider and travel distance to an In-Network Vision Provider, in a neighboring county, is more than 20 miles or 30 minutes travel time (or if you live in Fairfield County, 10 miles or 20 minutes travel time), We will pay benefits for Covered Services provided by an Out-of-Network Vision Provider as if the service was provided by an In-Network Vision Provider. Additionally, if You are unable to schedule an appointment with an In-Network Vision Provider within 15 business days, We will pay benefits for Covered Services provided by an Out-of-Network Vision Provider as if the service was provided by an In-Network Vision Provider. In order to ensure that the benefits are paid accordingly, We must be notified prior to receiving services from an Out-of-Network Vision Provider. Please call Us at 1-800-942-0854 for assistance.

NOTICE FOR RESIDENTS OF COLORADO

Domestic Partner

Colorado law provides that for dental insurance, domestic partners of Colorado's residents must be treated the same as spouses. If the certificate does not already have a definition of domestic partner, then the following definition applies:

> "**Domestic Partner** means each of two people, one of whom is an employee of the Policyholder, a resident of Colorado and who have registered as domestic partners or members of a civil union with the Colorado government or another government recognized by Colorado as having similar requirements."

If the certificate already has a definition of domestic partner, that definition will apply to Colorado residents, as long as it recognizes as a domestic partner any person registered as the employee's domestic partner with the Colorado government or another government recognized by Colorado as having similar requirements.

Wherever the term "**Spouse**" appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Wherever the term step-child appears, it is replaced by step-child or child of Your Domestic Partner.

Definition of Child

The term also includes newborns.

Vision Insurance: Coordination of Benefits

With respect to coordination of benefits, the benefits will never be less than what is shown under the following language.

This coordination of benefits (COB) provision applies when a Covered Person has vision coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits according to its policy terms without regard to the possibility that another Plan may cover some expenses. 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.

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for 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. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

   (1) Plan includes: Group insurance contracts, health maintenance organizations (HMO) contracts, closed panel plans or other forms of group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; vision benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) 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 means, in a COB provision, the part of the contract providing the vision 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 vision 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. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has vision care coverage under more than one Plan.

When This Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When This Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits, so that all Plan benefits do not exceed 100% of the total Allowable Expense.

D. Allowable expense is a vision care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses that are not Allowable expenses:

(1) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(2) 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.

(3) 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. Closed panel plan is a Plan that provides vision benefits to covered persons in the form of services through a panel of providers who are primarily employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. 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.

NOTICE FOR RESIDENTS OF COLORADO (continued)

ORDER OF BENEFIT DETERMINATION RULES

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

(2) 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 is excess to any other parts of the Plan provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

D. 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 Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

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

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

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

(i) If a court decree states that one of the parents is responsible for the dependent child's vision care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods commencing after the Plan is given notice of the court decree;

(ii) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

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

(iv) If a court decree 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 subsection (a) above determine the order of benefits; or

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

- The Plan covering the Custodial parent, first;
- The Plan covering the spouse of the Custodial parent, second;
- The Plan covering the non-custodial parent, third; and then;
- The Plan covering the spouse of the non-custodial parent, last

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

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

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

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

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

NOTICE FOR RESIDENTS OF COLORADO (continued)

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

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.

RIGHT TO RECEIVE AND RELEASE NEEDED 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 may get the facts from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Us any facts needed to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

If payments that should have been made under This plan are made by another Plan, the issuer has the right, at its discretion, to remit to the other Plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other Plan are considered benefits paid under This plan. To the extent of such payments, the issuer is fully discharged from liability under This plan.

RIGHT OF RECOVERY

We have the right to recover excess payment whenever We have paid Allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. We may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

If You have Questions about Coordination of Benefits, please contact 1-855-METEYE1

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

CAUTION: All vision plans have timely claim filing requirements. If You or Your provider fail to submit Your claim to a secondary vision plan within that plan's claim filing time limit, the plan can deny the claim. If You experience delays in the processing of Your claim by the primary health plan, You or Your provider will need to submit Your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if You are covered by more than one plan You should promptly report to Your vision providers and plans any changes in Your coverage.

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

NOTICE FOR RESIDENTS OF IDAHO

If the Subscriber has a question concerning the Subscriber's coverage or a claim, the Subscriber may call the toll free telephone number shown on the Certificate Face Page.

If the Subscriber is still concerned after contacting MetLife, the Subscriber should feel free to contact:

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, the Subscriber may write to:

MetLife
P.O. Box 997100
Sacramento, CA 95899-7100

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company

1-855-METEYE1

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at www.in.gov/idoi

NOTICE FOR RESIDENTS OF MAINE

The Subscriber have the right to designate a third party to receive notice if the Subscriber's insurance is in danger of lapsing due to a default on the Subscriber's part, such as for nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. The Subscriber may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once the Subscriber has made a designation, the Subscriber may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, the Subscriber, any person authorized to act on the Subscriber's behalf , or any covered Dependent may request reinstatement of the certificate on the basis that the Subscriber suffered from cognitive impairment or functional incapacity at the time of cancellation.

NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF VISION INSURANCE

1. If the Subscriber's Vision Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If the Subscriber's Vision Insurance ends because:

    - the Subscriber ceases to be in an Eligible Class; or
    - the Subscriber's employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of the Subscriber's Vision Insurance under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if the Subscriber becomes covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

CONTINUATION OF VISION INSURANCE FOR THE SUBSCRIBER'S FORMER SPOUSE OR STATE-REGISTERED DOMESTIC PARTNER

If the judgment of divorce dissolving the Subscriber's marriage provides for continuation of insurance for the Subscriber's former Spouse or State-Registered Domestic Partner when the Subscriber remarries, Vision Insurance for the Subscriber's former Spouse or State-Registered Domestic Partner that would otherwise end may be continued.

To continue Vision insurance under this provision:

1. the Subscriber must make a written request to the employer to continue such insurance;
2. the Subscriber must make any required premium to the employer for the cost of such insurance.

The request form will be furnished by the Employer.

Such insurance may be continued from the date the Subscriber's marriage is dissolved until the earliest of the following:

- the date the Subscriber's former Spouse or State-Registered Domestic Partner remarries;
- the date of expiration of the period of time specified in the divorce judgment during which the Subscriber is required to provide Vision Insurance for the Subscriber's former Spouse or State-Registered Domestic Partner;
- the date coverage is provided under any other group health plan;
- the date the Subscriber's former Spouse or State-Registered Domestic Partner becomes entitled to Medicare;
- the date Vision Insurance under the policy ends for all active employees, or for the class of active employees to which the Subscriber belonged before the Subscriber's employment terminated;
- the date of expiration of the last period for which the required premium payment was made; or
- the date such insurance would otherwise terminate under the policy.

If the Subscriber's former Spouse or State-Registered Domestic Partner is eligible to continue Vision Insurance under this provision and any other provision of this Policy, all such continuation periods will be deemed to run concurrently with each other and shall not be deemed to run consecutively.

NOTICE FOR RESIDENTS OF MISSISSIPPI

CLAIMS FOR VISION INSURANCE

Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-855-METEYE1.

Initial Determination

If the Subscriber's claim for Vision Insurance benefits is a Clean Claim and it is approved, benefits will be paid within 25 days after We receive Proof in an electronic form of a covered loss, or within 35 days after receipt of Proof in paper form of a covered loss. Proof includes, but is not limited to, information essential for Us to administer coordination of benefits.

"Clean Claim" means a claim that:

- does not require further information, adjustment or alteration by the Subscriber or the provider of the services in order to process and pay it;
- does not have any defects;
- does not have any impropriety, including any lack of supporting documentation; and
- does not involve a particular circumstance required special treatment that substantially prevents timely payments from being made on the claim.

A Clean Claim does not include a claim submitted by a provider more than 30 days after the date of service, or if the provider does not submit the claim on the Subscriber's behalf, a claim submitted more than 30 days after the date the provider bills the Subscriber. Errors, such as system errors, attributable to the insurer, do not change the clean claim status.

If We do not deny payment of such benefits to the Subscriber by the end of the 25 day period for clean claims submitted in electronic form, or 35 day period for Clean Claims submitted in paper form, and such benefits remain due and payable to the Subscriber, interest will accrue on the amount of such benefits at the rate of 3 percent per month until such benefits are finally settled. If We do not pay benefits to the Subscriber when due and payable, the Subscriber may bring action to recover such benefits, any interest which has accrued with respect to such benefits and any other damages which may be allowed by law. We will pay benefits when We receive satisfactory Proof of the Subscriber's claim.

If We are unable to pay a claim for Vision Insurance benefits because additional information or documentation is required, or there is a particular circumstance requiring special treatment, within 25 days after the date We receive the claim if it is submitted in electronic form, or within 35 days after the date MetLife receives the claim if it is submitted in paper form, We will send the Subscriber notice of what supporting documentation or information is needed. Any claim or portion of a claim for Vision Insurance benefits that is resubmitted with all of the supporting documentation requested in Our notice and becomes payable will be paid to the Subscriber within 20 days after it is received.

NOTICE FOR RESIDENTS OF MISSISSIPPI

Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

Initial Appeal. All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

Second Level Appeal. If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

Other Remedies. When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

Time of Action. No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy. If it is determined in such action that We acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, the Subscriber (or the provider, if the Subscriber assigned the benefits to the provider) shall be entitled to recover any interest which may accrue plus damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

Insurance Fraud: Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

NOTICE FOR NEW HAMPSHIRE RESIDENTS

CONTINUATION OF THE SUBSCRIBER'S VISION INSURANCE

If the Subscriber is a resident of New Hampshire, the Subscriber's Vision Insurance may be continued if it ends because the Subscriber's employment ends unless:

- the Subscriber's employment ends due to the Subscriber's gross misconduct;
- this Vision Insurance ends for all employees;
- this Vision Insurance is changed to end Vision Insurance for the class of employees to which the Subscriber belong;
- the Subscriber are entitled to enroll in Medicare; or
- the Subscriber's Vision Insurance ends because the Subscriber failed to pay the required premium.

The Employer must give the Subscriber written notice of:

- the Subscriber's right to continue the Subscriber's Vision Insurance;
- the amount of premium payment that is required to continue the Subscriber's Vision Insurance;
- the manner in which the Subscriber must request to continue the Subscriber's Vision Insurance and pay premiums; and
- the date by which premium payments will be due.

The premium that the Subscriber must pay for the Subscriber's continued Vision Insurance may include:

- any amount that the Subscriber contributed for the Subscriber's Vision Insurance before it ended;
- any amount the Employer paid; and
- an administrative charge which will not to exceed two percent of the rest of the premium.

To continue the Subscriber's Vision Insurance, the Subscriber must:

- send a written request to continue the Subscriber's Vision Insurance; and
- pay the first premium within 30 days after the date the Subscriber's employment ends.

The maximum continuation period will be the longest of:

- 36 months if the Subscriber's employment ends because the Subscriber retires, and within 12 months of retirement the Subscriber has a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if the Subscriber becomes entitled to disability benefits under Social Security within 60 days of the date the Subscriber's Employment ends; or
- 18 months.

The Subscriber's continued Vision Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Vision Insurance ends;
- the date this Vision Insurance is changed to end Vision Insurance for the class of employees to which the Subscriber belongs;
- the date the Subscriber are entitled to enroll for Medicare;
- if the Subscriber does not pay the required premium to continue the Subscriber's Vision Insurance; or
- the date the Subscriber becomes eligible for coverage under any other group Vision coverage.

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF THE SUBSCRIBER'S DEPENDENT'S VISION INSURANCE

If the Subscriber is a resident of New Hampshire, the Subscriber's Vision Insurance for the Subscriber's Dependents may be continued if it ends because the Subscriber's employment ends, the Subscriber's marriage ends in divorce or separation, or the Subscriber dies, unless:

- the Subscriber's employment ends due to the Subscriber's gross misconduct;
- this Vision Insurance ends for all Dependents;
- this Vision Insurance is changed, for the class of employees to which the Subscriber belongs, to end Vision Insurance for Dependents;
- the Dependent is entitled to enroll in Medicare; or
- the Subscriber's Vision Insurance for the Subscriber's Dependents ends because the Subscriber fails to pay a required premium.

If Vision Insurance for the Subscriber's Dependents ends because the Subscriber's marriage ends in divorce or separation, the party responsible under the divorce decree or separation agreement for payment of premium for continued Vision Insurance must notify the employer, in writing, within 30 days of the date of the divorce decree or separation agreement that the divorce or separation has occurred. If the Subscriber and the Subscriber's divorced or separated Spouse or State-Registered Domestic Partner share responsibility for payment of the premium for continued Vision Insurance, both the Subscriber and the Subscriber's divorced or separated Spouse or State-Registered Domestic Partner must provide the notification.

The Employer must give the Subscriber, or the Subscriber's former Spouse or State-Registered Domestic Partner if the Subscriber has died or the Subscriber's marriage has ended, written notice of:

- the Subscriber's right to continue the Subscriber's Vision Insurance for the Subscriber's Dependents;
- the amount of premium payment that is required to continue the Subscriber's Vision Insurance for the Subscriber's Dependents;
- the manner in which the Subscriber or the Subscriber's former Spouse or State-Registered Domestic Partner must request to continue the Subscriber's Vision Insurance for the Subscriber's Dependents and pay premiums; and
- the date by which premium payments will be due.

The premium that the Subscriber or the Subscriber's former Spouse or State-Registered Domestic Partner must pay for continued Vision Insurance for the Subscriber's Dependents may include:

- any amount that the Subscriber contributed for the Subscriber's Vision Insurance before it ended; and
- any amount the Employer paid.

To continue Vision Insurance for the Subscriber's Dependents, the Subscriber or the Subscriber's former Spouse or State-Registered Domestic Partner must:

- send a written request to continue Vision Insurance for the Subscriber's Dependents; and
- must pay the first premium within 30 days of the date Vision Insurance for the Subscriber's Dependents ends.

If the Subscriber, and the Subscriber's former Spouse or State-Registered Domestic Partner, if applicable, fail to provide any required notification, or fail to request to continue Vision Insurance for the Subscriber's Dependents and pay the first premium within the time limits stated in this section, the Subscriber's right to continue Vision Insurance for the Subscriber's Dependents will end.

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF THE SUBSCRIBER'S DEPENDENT'S VISION INSURANCE (Continued)

The maximum continuation period will be the longest of the following that applies:

- 36 months if Vision Insurance for the Subscriber's Dependents ends because the Subscriber's marriage ends in divorce or separation, except that with respect to a Spouse or State-Registered Domestic Partner who is age 55 or older when the Subscriber's marriage ends in divorce or separation the maximum continuation period will end when the divorced or separated Spouse or State-Registered Domestic Partner becomes eligible for Medicare or eligible for participation in another employer's group plan;
- 36 months if Vision Insurance for the Subscriber's Dependents ends because the Subscriber dies, except that with respect to a Spouse or State-Registered Domestic Partner who is age 55 or older when the Subscriber dies, the maximum continuation period will end when the Subscriber's surviving Spouse or State-Registered Domestic Partner becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months if Vision Insurance for the Subscriber's Dependents ends because the Subscriber becomes entitled to benefits under Title XVIII of Social Security, except that with respect to a Spouse or State-Registered Domestic Partner who is age 55 or older when the Subscriber becomes entitled to benefits under Title XVIII of Social Security, the maximum continuation period will end when the divorced or separated Spouse or State-Registered Domestic Partner becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months if the Subscriber becomes entitled to benefits under Title XVIII of Social Security while the Subscriber is already receiving continued benefits under this section, except that with respect to a Spouse or State-Registered Domestic Partner who is age 55 or older when the Subscriber first becomes entitled to continue the Subscriber's Vision Insurance the maximum continuation period will end when the divorced or separated Spouse or State-Registered Domestic Partner becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months with respect to a Dependent Child if Vision Insurance ends because the Child ceases to be a Dependent Child;
- 36 months if the Subscriber's employment ends because the Subscriber retires, and within 12 months of retirement the Subscriber has a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if Vision Insurance for the Subscriber's Dependents ends because the Subscriber's employment ends, and within 60 days of the date the Subscriber's employment ends you become entitled to disability benefits under Social Security; or
- 18 months if Vision Insurance for the Subscriber's Dependents ends because the Subscriber's employment ends.

A Dependent's continued Vision Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Vision Insurance ends;
- the date this Vision Insurance is changed to end Vision Insurance for Dependents for the class of employees to which the Subscriber belongs;
- the date the Dependent becomes entitled to enroll for Medicare;
- if the Subscriber does not pay a required premium to continue Vision Insurance for the Subscriber's Dependents; or
- the date the Dependent becomes eligible for coverage under any other group vision coverage.

NOTICE FOR RESIDENTS OF NEW MEXICO

Consumer Complaint Notice

If the Subscriber is a resident of New Mexico, the Subscriber's coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If the Subscriber has concerns regarding a claim, premium, or other matters relating to this coverage, the Subscriber may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: https://www.osi.state.nm.us/ConsumerAssistance/index.aspx.

NOTICE FOR RESIDENTS OF PENNSYLVANIA

Vision Insurance for a Dependent Child may be continued past the age limit if that Child is a full-time student and insurance ends due to the Child being ordered to active duty (other than active duty for training) for 30 or more consecutive days as a member of the Pennsylvania National Guard or a Reserve Component of the Armed Forces of the United States.

Insurance will continue if such Child:

- re-enrolls as a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
- re-enrolls for the first term or semester, beginning 60 or more days from the child's release from active duty;
- continues to qualify as a Child, except for the age limit; and
- submits the required Proof of the child's active duty in the National Guard or a Reserve Component of the United States Armed Forces.

Subject to the When Vision Coverage Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR THE SUBSCRIBER AND THE SUBSCRIBER'S DEPENDENTS, this continuation will continue until the earliest of the date:

- the insurance has been continued for a period of time equal to the duration of the child's service on active duty; or
- the child is no longer a full-time student.

NOTICE FOR RESIDENTS OF TEXAS

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

NOTICE FOR RESIDENTS OF TEXAS

If You are a resident of Texas and live in a county where there is no In-Network Vision Provider and travel distance to an In-Network Vision Provider is more than 90 minutes travel time and 75 miles away, We will pay benefits for Covered Services provided by an Out-of-Network Vision Provider as if the service was provided by an In-Network Vision Provider. In order to ensure that the benefits are paid accordingly, We must be notified prior to receiving services from an Out-of-Network Vision Provider. Please call Us at 1-855-METEYE1 for assistance.

If You or a Dependent receive emergency or urgent vision care from an Out-of-Network Vision Provider, We will pay benefits for those Covered Services provided by an Out-of-Network Vision Provider as if the services were provided by an In-Network Vision Provider.

NOTICE FOR RESIDENTS OF TEXAS

If the Subscriber resides in Texas, note the following Procedures for Vision Claims will be followed:

Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-855-METEYE1.

Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

Initial Appeal. All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

Second Level Appeal. If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

Other Remedies. When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

Time of Action. No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy.

Insurance Fraud: Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

NOTICE FOR RESIDENTS OF UTAH

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides **a brief summary** of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Accident and Health Insurance
  - o $500,000 for health benefit plans
  - o $500,000 in disability income insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to health benefit plans.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

Benefits provided by a long-term care rider to a life insurance or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, please visit the Association's website at www.ulhiga.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
466 South 500 East, Suite 100
Salt Lake City UT 84102
(801) 320-9955 (801) 957-9200

Utah Insurance Department
4315 S. 2700 W., Suite 2300
Taylorsville, UT 84129

NOTICE TO RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING THE SUBSCRIBER'S INSURANCE

In the event the Subscriber needs to contact someone about this insurance for any reason please contact the Subscriber's agent. If no agent was involved in the sale of this insurance, or if the Subscriber has additional questions the Subscriber may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
P.O. Box 997100
Sacramento, CA 95899-7100
Attn: Corporate Consumer Relations Department

To phone in a claim related question, the Subscriber may call Claims Customer Service at:
1-855-METEYE1

If the Subscriber has any questions regarding an appeal or grievance concerning the vision services that the Subscriber have been provided that have not been satisfactorily addressed by this Vision Insurance, the Subscriber may contact the Virginia Office of the Managed Care Ombudsman for assistance.

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
1-804-371-9691 - phone
1-877-310-6560 - toll-free
1-804-371-9944 - fax
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

Or:

Office of Licensure and Certification
Division of Acute Care Services
Virginia Department of Health
9960 Mayland Drive
Suite 401
Henrico, Virginia 23233-1463
Phone number: 1-800-955-1819/ local: 804-367-2106
Fax: (804) 527-4503
MCHIP@vdh.virginia.gov

Written correspondence is preferable so that a record of the Subscriber's inquiry is maintained. When contacting the Subscriber's agent, company or the Bureau of Insurance, have the Subscriber's policy number available.

NOTICE TO RESIDENTS OF VIRGINIA (continued)

VISION INSURANCE: PROCEDURES FOR VISION CLAIMS

Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-855-METEYE1.

Claim Denial Appeals

If a claim is denied in whole or in part, under the terms of this certificate, a request may be submitted to Us by a Covered Person or a Covered Person's authorized representative for a full review of the denial. A Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include the Covered Person's authorized representative, where applicable.

Initial Appeal. All requests for review must be made within one hundred eighty (180) calendar days following denial of a claim. A Covered Person may review, during normal business hours, any documents used by Us pertinent to the denial. A Covered Person may also submit Written comments or supporting documentation concerning the claim to assist in Our review. Our response to the initial appeal, including specific reasons for the decision, shall be communicated to the Covered Person within thirty (30) calendar days after receipt of the request for the appeal.

Second Level Appeal. If a Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has the right to a second level appeal. A request for a second level appeal must be submitted to Us within sixty (60) calendar days after receipt of Our response to the initial appeal. We shall communicate Our final determination to the Covered Person within thirty (30) calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to the Covered Person shall include the specific reasons for the determination.

Other Remedies. When a Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Additional information is available from the U.S. Department of Labor or the insurance regulatory agency for the Covered Persons' state of residency. Additionally, under the provisions of ERISA (Section 502(a)(1)(B) 29 U.S.C. 1132(a)(1)(B)), the Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed. ERISA remedies may apply in those instances where the claims were not approved in whole or in part as the result of appeals under this Policy and the Covered Person disagrees with the outcome of such appeals.

Time of Action. No action in law or in equity shall be brought to recover on this Policy prior to the Covered Person exhausting his/her rights under this Policy and/or prior to the expiration of sixty (60) calendar days after the claim and any applicable documentation has been filed with Us. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of this Policy. No such action shall be brought after the expiration of three (3) years from the last date that the claim and any applicable invoices were submitted to Us, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of this Policy.

Insurance Fraud: Any Covered Person who intends to defraud, knowingly facilitates a fraud, submits a claim containing false or deceptive information, or who commits any other similar act as defined by applicable state or federal law, is guilty of insurance fraud. Such an act is grounds for immediate termination of the coverage under this Policy of the Covered Person committing such fraud.

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH THE SUBSCRIBER'S INSURANCE PAPERS

PROBLEMS WITH THE SUBSCRIBER'S INSURANCE? - If the Subscriber is having problems with the Subscriber's insurance company or agent, do not hesitate to contact the insurance company or agent to resolve the Subscriber's problem.

Metlife
Attn: Corporate Consumer Relations Department
P.O. Box 997100
Sacramento, CA 95899-7100
1-855-METEYE1

The Subscriber can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. The Subscriber can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.