YOUR BENEFIT PLAN

WA State Health Care Authority SEBB

All Actively at Work school district employees of an Employing Agency who elect MetLife Vision Insurance, excluding employees who reside in Washington, if Your school district elects to offer coverage

Vision Insurance for You and Your Dependents

Certificate Date: January 1, 2020

Certificate Number 2

WA State Health Care Authority SEBB
626 8th Avenue SE
P.O. Box 42720
Olympia, WA 98504

TO EMPLOYEES:

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 SEBB

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 You and Your Dependents are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

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

Policyholder:	WA State Health Care Authority SEBB
Group Policy Number:	219743-2-G
Type of Insurance:	Vision Insurance
MetLife Toll Free Number(s): **For Claim Information**	FOR VISION CLAIMS: 1-833-854-9624

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 Your Rights and Responsibilities

Rights:

- We will treat communications, financial records and records pertaining to Your care in accordance with all applicable laws relating to privacy.
- Decisions with respect to vision treatment are the responsibility of You 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.
- You may request a written response from MetLife to any written concern or complaint.

Responsibilities:

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

TABLE OF CONTENTS

Section **Page**

SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents will only be insured for the benefits:

- for which You and Your Dependents become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

BENEFIT BENEFIT AMOUNTS AND HIGHLIGHTS

Vision Insurance For You and Your Dependents

Employee and Spouse:

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

Children:

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 *Co-payment shall not apply to Retinal Imaging*	$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 frequency)	**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 of at least $1 up to $39. You will not be responsible for an amount charged in excess of $39. If the amount charged is under $39, then You 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 Your 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 after Materials co-pay*** 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	Ultra Violet 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 Polycarbonate (adult) Scratch Resistant Coating (adult) Anti-Reflective Coating Tints Photochromic Note: These lens options are available at a discount with "not to exceed" pricing/maximum copay. All lens options are available at participating private practice provider offices and the copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. All lens options and “not to exceed” copays and pricing are not available at Costco or Walmart (including Sam’s Club). Please contact your local Costco or Walmart (including 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, and Photochromatic applied to the allowance for the applicable corrective lens
FRAMES	**Covered up to a $150* allowance** Frames are covered up to the allowance of $85* at Costco or Walmart (including Sam’s Club) and $150* 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	**Employee and Spouse:** **Standard and Premium fit:** Covered in full with a co-pay not to exceed $60. **Children:** **Covered in full***	**Applied to the allowance for the contact lenses**
ELECTIVE	**Employee and Spouse:** **Covered up to $150** Contact lenses are provided in place of lens and frame benefits available herein. **Children:** **Covered up to $300**	**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.

** Less any applicable Co-payment.*

SCHEDULE OF BENEFITS (continued)

Value-Added Features Available At In-Network Vision Providers[2] (These features are not insurance.)	
LASER VISION CORRECTION	Savings between 1% - 15% off the regular price, or 1% - 5% off a promotional offer, for laser surgery including PRK, LASIK, and Custom LASIK. Please check with your provider for details applicable to their Laser Vision Correction and which discount ("savings") You would be eligible for. This is considered a negotiated discount for You. You are 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.[1]

[1] These features may not be available in all states and with all In-Network Vision Providers. Please check with Your In-Network Vision Provider.
[2] As provided by Vision Service Plan Choice Network.

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.

Actively at Work or **Active Work** means that You are performing all of the usual and customary duties of Your job on a Full-Time or Part-Time basis. This must be done at:

- Your Employing Agency's place of business;
- an alternate place approved by Your Employing Agency; or
- a place to which the Employing Agency's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Employing Agency approved paid leave of absence, holidays, business closures, or while on approved leave of absence without pay.

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

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

Covered Person(s) means an Employee and/or a Dependent covered under this Certificate.

Covered Services and Materials mean a vision service or materials used to treat Your or Your Dependent'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 Your Spouse and/or child.

Employing Agency means any entity that is authorized under Washington law that is approved by WA State Health Care Authority to participate.

Full-Time means anticipated Active Work of at least six hundred thirty hours per school year on the Employing Agency's regular work schedule for the eligible class of employees to which You belong.

In-Network Vision Provider means an optometrist, ophthalmologist, or optician licensed and otherwise qualified to practice vision care and/or provide vision care materials 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

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.

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.

DEFINITIONS (continued)

Out-of-Network Vision Provider/Non-Network Vision Provider means any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted to provide vision care services and/or vision care materials to Covered Persons of MetLife.

Part-Time means anticipated Active Work less than 630 hours per school year on the Employing Agency's regular work schedule for the eligible class of employees to which You belong as referenced in WAC 182-30-130.

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.

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 Your lawful spouse. Wherever the term "Spouse" appears in the certificate it shall, unless otherwise specified, be read to include Your State-Registered Domestic Partner.

For the purposes of determining who may become covered for insurance, the term does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

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 on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

DEFINITIONS (continued)

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;
- 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.

You and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU AND YOUR DEPENDENTS

ELIGIBLE CLASS(ES)

All Actively at Work school district employees of an Employing Agency who elect MetLife Vision Insurance, excluding employees who reside in Washington, if Your school district elects to offer coverage.

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

If You are in an eligible class on January 1, 2020, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after January 1, 2020, You will be eligible for insurance on the date You enter that class.

Vision Plan Eligibility and Enrollment

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

ELIGIBILITY

The school employee’s SEBB Organization will inform the school employee whether or not they are eligible for benefits upon employment and whenever their eligibility status changes. The communication will include information about the school employee’s right to appeal eligibility and enrollment decisions. Information about a school employee’s right to an appeal can be found on page 19 of this certificate of coverage. For information on how to enroll see the “Enrollment” section.

To enroll an eligible dependent the subscriber must follow the procedural requirements described in the “Enrollment” section. The SEBB Program or SEBB Organization verifies the eligibility of all dependents and requires the subscriber to provide documents that prove a dependent’s eligibility.

The following are eligible as dependents:

1. Legal spouse.
2. State-registered domestic partner.
3. Children. Children are eligible through the last day of the month in which their 26th birthday occurs except as described in subsection (g) of this section. Children are defined as the subscriber’s:
    a. Children as defined in state statutes that establish a parent-child relationship, except when parental rights have been terminated;
    b. Children of the subscriber’s spouse, based on the spouse’s establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild’s relationship to a subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;
    c. Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
    d. Children of the subscriber’s state-registered domestic partner, based on the state-registered domestic partner’s establishment of a parent-child relationship, except when parental rights have been terminated. The child’s relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber’s legal relationship with the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death;

e. Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;

f. Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include a foster child unless the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and

g. Children of any age with a developmental or physical disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age of 26. The following requirements apply to dependents with a disability:

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

ENROLLMENT

A subscriber or subscriber's dependent is eligible to enroll in only one SEBB vision plan even if eligibility criteria is met under two or more subscribers. For example, a dependent child who is eligible for enrollment under two parents working for the same or different SEBB Organizations may be enrolled as a dependent under one parent, but not more than one.

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

How to enroll

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

To enroll an eligible dependent, the school employee must include the dependent's information on the form and provide the required document(s) as proof of the dependent's eligibility. A dependent must be enrolled in the same health plan coverage as the subscriber. The dependent will not be enrolled if their eligibility is not verified.

All other subscribers may enroll by submitting the required forms to the SEBB Program. The school employee's elections must be received by the SEBB program no later than sixty days from the date the school employee's SEBB health plan coverage ended or from the postmark date on the election notice sent by the SEBB program, whichever is later. The school employee's first premium payment and applicable premium surcharges are due no later than forty-five days after the election ends as described above. Premiums associated with continuing SEBB vision insurance coverage must be made to the HCA. For more information see “Options for continuing SEBB vision coverage” on page 17.

A subscriber or their dependents may also enroll during the SEBB Program’s annual open enrollment (see “Annual open enrollment” on page 14) or during a special open enrollment (see “Special open enrollment” beginning on page 14). The subscriber must provide proof of the event that created the special open enrollment.

A school employee must notify their SEBB Organization to remove dependents within 60 days from the last day of the month when the dependent no longer meets the eligibility criteria described under “Eligible Dependents” on page 11**. All other subscribers** must notify the SEBB Program **to remove a dependent** within 60 days from the last day of the month when the dependent no longer meets the eligibility criteria described under “Eligible dependents” on page 11. Consequences for not submitting notice within 60 days may include, but are not limited to:

- The dependent losing eligibility to continue vision plan coverage under one of the continuation coverage options described on page 17 of this certificate of coverage.
- The subscriber being billed for claims paid by the vision plan that were received after the dependent lost eligibility;
- The subscriber being unable to recover subscriber-paid insurance premiums for a dependent that lost their eligibility; and
- The subscriber being responsible for premiums paid by the state for the dependent's vision plan coverage after the dependent lost eligibility.

WHEN VISION COVERAGE BEGINS

For a school employee and their eligible dependents **enrolling during the first annual open enrollment**, vision coverage begins on January 1, 2020.

For a school employee and their eligible dependents **enrolling when the school employee is newly eligible**, vision coverage begins the first day of the month following the date the school employee becomes eligible. The school employee’s benefits will begin on the first day of work when their first day of work is on or after September 1, but not later than the first day of school for the current school year as established by the SEBB Organization.

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

Exceptions:

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

   - For a spouse or state-registered domestic partner of a subscriber, vision coverage will begin the first day of the month in which the event occurs.
2. For a spouse or state-registered domestic partner of a subscriber, vision coverage begins the first day of the month in which the event occurs.
3. If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, vision coverage begins on the first day of the month following eligibility certification

ANNUAL OPEN ENROLLMENT

School employees may make the following changes to their enrollment during the SEBB Program's annual open enrollment:

- Enroll or remove eligible dependents; or
- Change their vision plan.

Other Subscribers may make the following changes to their enrollment during the SEBB Program's annual open enrollment:

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

The school employee must submit the change online or return the required enrollment/change form to their SEBB Organization. All other subscribers must submit the form to the SEBB Program. The form must be received no later than the last day of the annual open enrollment. The enrollment change will become effective January 1st of the following year.

SPECIAL OPEN ENROLLMENT

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

- Change their vision plan; or
- Enroll or remove eligible dependents.

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

Exception: If a school employee wants to enroll a newborn or child whom the school employee has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the school employee should notify their SEBB organization by submitting an enrollment form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required enrollment/change form must be received no later than sixty days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption. School employees should contact their personnel, payroll, or benefits office for the required forms.

See "Adding a New Dependent to Your Coverage" on page 16.

WHEN CAN A SUBSCRIBER CHANGE THEIR HEALTH PLAN

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

1. Subscriber gains a new dependent due to:
    a. Marriage or registering a state-domestic partnership;
    b. Birth, adoption or when the subscriber assumes a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becomes eligible as an extended dependent through legal custody or legal guardianship.
2. Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber has a change in employment status that affects their eligibility for the employer contribution toward their employer-based group health plan;
4. Subscriber has a change in employment from a SEBB organization to a public school that straddles county lines or is in a county that borders Idaho or Oregon, which results in the subscriber having different medical plans available. The subscriber may change their election if the change in employment causes:
    a. The subscriber's current medical plan to no longer be available, in this case the subscriber may select from any available medical plan; or
    b. The subscriber has one or more new medical plans available, in this case the subscriber may select to enroll in a newly available plan.
    c. As used in this subsection the term "public school" shall be interpreted to not include charter schools and educational service districts.
5. Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
6. Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber moves and their current health plan is not available in the new location, the subscriber must select a new health plan otherwise there will be limited network providers and covered services;
7. A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);
8. Subscriber or their dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or the subscriber's dependent loses eligibility for coverage under Medicaid or CHIP;
9. Subscriber or their dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from Medicaid or a state CHIP;
10. Subscriber or their dependent becomes entitled to coverage under Medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicare. If the subscriber's current health plan becomes unavailable due to the subscriber's or a subscriber's dependent's entitlement to Medicare, the subscriber must select a new health plan as described in WAC 182-30-085(1);
11. Subscriber or their dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA); or
12. Subscriber or their dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or their dependent for a specific condition or ongoing course of treatment. The subscriber may not change their health plan election if the subscriber or a subscriber's dependent physician stops participation with the subscriber's health plan unless the SEBB Program determines that a continuity of care issue exists. The SEBB Program will consider but is not limited to considering the following:
    a. Active cancer treatment such as chemotherapy or radiation therapy;

b. Treatment following a recent organ transplant;

c. A scheduled surgery;

d. Recent major surgery still within the postoperative period; or

e. Treatment of a high risk pregnancy.

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

WHEN MAY A SUSBSCRIBER ENROLL OR REMOVE ELIGIBLE DEPENDENTS

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

1. Subscriber gains a new dependent due to:
    a. Marriage or registering a domestic partnership;
    b. Birth, adoption or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber has a change in employment status that affects the subscriber's eligibility for the employer contribution toward their employer-based group health plan;
4. The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;
5. Subscriber or a subscriber's dependent has a change in enrollment under another employer-based group health insurance plan during its annual open enrollment that does not align with the SEBB Program's annual open enrollment;
6. Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and that change in residence results in the dependent losing their health insurance;
7. A court order requires the subscriber, or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);
8. Subscriber or their dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP) program, or the subscriber or a subscriber's dependent loses eligibility for coverage under Medicaid or CHIP; or
9. Subscriber or their dependent becomes eligible for a state premium assistance subsidy for SEBB health plan coverage from Medicaid or a state CHIP.

WHEN VISION COVERAGE ENDS

Vision coverage ends on the following dates:

1. The SEBB Organization terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the employer-initiated termination notice is effective;
2. The school employee terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the school employee's resignation is effective;

3. The school employee's work pattern is revised such that the school employee is no longer anticipated to work six hundred thirty (630) hours during the school year. In this case, eligibility for the employer contribution ends as of the last day of the month in which the change is effective;
4. The date the Group Policy ends;
5. the end of the period for which the last premium has been paid for You or Your dependents;
6. The date You cease to be in an eligible class;
7. With respect to dependents, the last day of the calendar month the person ceases to be a dependent;
8. The last day of the calendar month in which You retire in accordance with Your applicable retirement plan;
9. The date You die; or
10. The date Your Employing Agency ceases to participate in the Group Policy.

Premium payments and applicable premium surcharges become due the first of the month in which vision coverage is effective. Premium payments and applicable premium surcharges are not prorated during any month, even if an enrollee dies or asks to terminate their vision before the end of the month.

When vision plan enrollment ends, the enrollee may be eligible for continuation coverage or conversion to other vision coverage if they apply within the timelines explained in the “Options for continuing SEBB vision coverage” on page 17.

If a subscriber enrolls in continuation coverage, the subscriber is responsible for timely payment of premiums and applicable premium surcharges. If the monthly premium or applicable premium surcharge remains unpaid for 30 days, it will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premium or applicable premium surcharge becomes delinquent to pay the unpaid premium balance or surcharge. If the subscriber’s premium balance or applicable premium surcharge remains unpaid for 60 days from the original due date, the subscriber’s vision coverage (including enrolled dependents) will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharge was paid.

A school employee who needs the required forms for an enrollment or benefit change may contact their SEBB Organization. All other subscribers may contact the SEBB Program at the 1-800-200-1004.

OPTIONS FOR CONTINUATION SEBB VISION COVERAGE

A school employee and their dependent covered by this vision plan has options for continuing insurance coverage during temporary or permanent loss of eligibility. There are two continuation coverage options for SEBB vision plan enrollees:

1. SEBB Continuation Coverage (COBRA)
2. SEBB Continuation Coverage (Unpaid Leave)

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

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

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

TRANSITIONAL CONTINUATION COVERAGE

School employees and their dependents may gain temporary eligibility for School Employees Benefits Board (SEBB) benefits, on a self-pay basis, if they meet the following criteria:

1. A school employee and their dependents who are enrolled in vision under a group plan offered by a SEBB organization on December 31, 2019, who lose eligibility because the school employee is not eligible for SEBB benefits, may elect to enroll in the following SEBB benefits: Vision coverage. These benefits will be provided for a maximum of eighteen months.
2. A dependent of a SEBB eligible school employee who is enrolled in vision under a school employee's account on December 31, 2019, who loses eligibility because they are not an eligible dependent may enroll in vision for a maximum of thirty-six months.
3. A dependent of a school employee who is continuing vision coverage through a SEBB organization on December 31, 2019, may elect to finish out their remaining months, up to the maximum number of months authorized by Consolidated Omnibus Budget Reconciliation Act (COBRA) for a similar event, by enrolling in a vision plan offered through the SEBB program.

FAMILY AND MEDICAL LEAVE ACT OF 1993

A school employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward SEBB insurance coverage in accordance with the FMLA. The SEBB Organization determines if the school employee is eligible for leave and the duration of the leave under FMLA. The school employee must continue to pay the school employee monthly premium contribution and applicable premium surcharge during this period to maintain eligibility. If the school employee's monthly premium or applicable premium surcharge remains unpaid for 60 days from the original due date, insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid.

If a school employee exhausts the period of leave approved under FMLA, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharge set by the Health Care Authority (HCA), with no contribution from the SEBB Organization while on approved leave. For additional information on continuation coverage, see the section titled "Options for continuing SEBB vision coverage."

PAID FAMILY MEDICAL LEAVE ACT

A school employee on approved leave under the Washington state Paid Family and Medical Leave Program (PFML) may continue to receive the employer contribution toward SEBB insurance coverage in accordance with PFML. The Employment Security Department determines if the school employee is eligible for leave and the duration of the leave under PFML. The school employee must continue to pay the school employee monthly premium contribution and applicable premium surcharge during this period to maintain eligibility. If the school employee's monthly premium or applicable premium surcharge remains unpaid for 60 days from the original due date, insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU AND YOUR DEPENDENTS (continued)

If a school employee exhausts the period of leave approved under PFML, they may continue insurance coverage by self-paying the monthly premium and applicable premium surcharge set by HCA, with no contribution from the SEBB Organization while on approved leave. For additional information on continuation coverage, see the section titled “Options for Continuing SEBB Vision Coverage” on page 17.

PAYMENT OF PREMIUM DURING A LABOR DISPUTE

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

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

APPEAL RIGHTS

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

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

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

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR DEVELOPMENTALLY DISABLED, MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if that child is incapable of self-sustaining employment because of a developmental disability, mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 60 days after the date the Child attains the age limit and at reasonable intervals after such date, but not more frequently than once a year after the two-year period following the child's attainment of the limiting age.

Subject to the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, insurance will continue while such Child:

- remains incapable of self-sustaining employment because of a developmental disability, mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

COBRA CONTINUATION FOR VISION INSURANCE

If Vision Insurance for You or a Dependent ends, You or Your Dependent may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the COBRA section of Your summary plan description or contact Your Employing Agency for information regarding continuation of insurance under COBRA.

VISION INSURANCE

Benefits are available for Covered Services and Materials provided by either In-Network Vision Providers or Out-of-Network Vision Providers. However, You may be able to reduce Your 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. You are always free to receive services from any Vision Provider. You 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 You or a Dependent incur 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, You 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 You should or should not receive the service. You and Your 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 You confirm that the Vision Provider is currently an In-Network Vision Provider at the time that the Covered Services and Materials are provided.

You can obtain a customized listing of MetLife's In-Network Vision Providers either by calling 1-833-854-9624 or by visiting Our website at www.metlife.com/mybenefits.

PLAN BENEFITS

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

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

If You or Your Dependent receive Covered Services and Materials from an Out-of-Network Vision Provider, and You assign payment of Vision Insurance benefits to Your or Your Dependent's Vision Provider, We will pay benefits directly to the Vision Provider. Otherwise, We will pay Vision Insurance benefits to You.

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, You 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.

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

Necessary Contact Lenses

Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Vision Provider. Generally, coverage will be authorized for the following reasons:

- Aphakia—379.31 or 743.35.
- Nystagmus—379.50 through 379.56, 386.11, 386.12 or 386.2.
- Keratoconus—371.60, 371.61, 371.62, 743.41, or 743.42.
- Corneal transplant—V42.5.
- Corneal dystrophies—371.50 through 371.58.
- Anisometropia greater than or equal to 2.00 diopters difference in any meridian based on the spectacle prescription.
- High ametropia greater than or equal to ±10.00 diopters in either eye in any meridian based on the spectacle prescription.
- Irregular astigmatism—367.22.

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 You have questions about the diagnoses listed above or the codes included with the diagnoses, please contact Your 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:

   - eyesizes 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, You 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.
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 You or Your Dependent 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. You must promptly claim and notify the Company of all such benefits.
16. Local, state and/or federal taxes.
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 and materials obtained while outside the United States.
20. 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) The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense,** unless one of the **Plans** provides coverage for private hospital room expenses.

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

(3) If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense.**

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 You have Questions about Coordination of Benefits, please contact MetLife at 1-833-854-9624.

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.

VISION INSURANCE: COORDINATION OF BENEFITS (continued)

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."

VISION INSURANCE: FILING A CLAIM

CLAIMS FOR VISION INSURANCE

If you select an In Network Vision Provider, You do not need to file a claim.

If you select an Out-of-Network Vision Provider, You 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 Your claim form, or You 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. You 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 1-833-854-9624. 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, Your 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 1-833-854-9624.

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, You may assign Vision Insurance benefits to the Vision Provider providing such service.

Vision Insurance: Who We Will Pay

If You assign payment of Vision Insurance benefits to Your or Your Dependent's Vision Provider, We will pay benefits directly to the Vision Provider. Otherwise, We will pay Vision Insurance benefits to You.

Entire Contract

Your 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 You

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

Evidence of insurability will not be required nor will any statement made by You, 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.

THIS IS THE END OF THE CERTIFICATE.

THE FOLLOWING IS ADDITIONAL INFORMATION.

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.