



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 Employer and may be changed or ended without Your consent or notice to You.

Employer: East Texas Employee Benefits Cooperative  
Group Policy Number: TS 05374366-G  
Type of Insurance: Vision Insurance  
MetLife Toll Free Number(s):  
For Claim Information 1-855-METEYE1

### **THIS CERTIFICATE ONLY DESCRIBES VISION INSURANCE.**

**FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON YOUR EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.**

**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 Residents of North Dakota:** If you are not satisfied with your Certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under Your Certificate. We will refund within 30 days of our receipt of the returned Certificate 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.

**GCERT2008-JPA-TX**  
**fp**

**1 All Active Full-Time Employees who elect the  
High Option Vision Plan  
RV 06/21/2022**

**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](mailto: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](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

### **¿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.

### **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](mailto: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](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

**NOTICE FOR RESIDENTS OF ALL STATES**

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

## **NOTICE FOR RESIDENTS OF ARKANSAS**

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You 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). You 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 DEPARTMENT 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 Employer, a resident of California and who have registered as domestic partners or members of a civil union with the California or another government recognized by California as having similar requirements.

For purposes of determining who may become a Covered Person, the term does not include any person who:

- is in the military of any country or subdivision of a country;
- is insured under the Group Policy as an employee."

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, except in the definition of Spouse, it shall be replaced by Spouse or 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 30 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 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 You have a question concerning Your coverage or a claim, first contact the Employer. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Employer and MetLife, You should feel free to contact:

Idaho Department of Insurance  
Consumer Affairs  
700 West State Street, 3<sup>rd</sup> 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](http://www.DOI.Idaho.gov)

# NOTICE FOR RESIDENTS OF ILLINOIS

## IMPORTANT NOTICE

To make a complaint to MetLife, You 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](http://www.in.gov/idoi)

## **NOTICE FOR RESIDENTS OF MAINE**

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as 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. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You 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, You, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

# NOTICE FOR RESIDENTS OF MASSACHUSETTS

## CONTINUATION OF VISION INSURANCE

1. If Your 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 Your Vision Insurance ends because:
  - You cease to be in an Eligible Class; or
  - Your 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 Your Vision Insurance under the CONTINUATION WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become 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 YOUR FORMER SPOUSE

If the judgment of divorce dissolving Your marriage provides for continuation of insurance for Your former Spouse when You remarry, Vision Insurance for Your former Spouse that would otherwise end may be continued.

To continue Vision insurance under this provision:

1. You must make a written request to the employer to continue such insurance;
2. You 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 Your marriage is dissolved until the earliest of the following:

- the date Your former Spouse remarries;
- the date of expiration of the period of time specified in the divorce judgment during which You are required to provide Vision Insurance for Your former Spouse;
- the date coverage is provided under any other group health plan;
- the date Your former Spouse 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 You belonged before Your 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 Your former Spouse 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 Your 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 You 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 Your behalf, a claim submitted more than 30 days after the date the provider bills You. 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 You 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 You, 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 You when due and payable, You 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 Your 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 You 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 You 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, You (or the provider, if You 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 YOUR VISION INSURANCE**

If You are a resident of New Hampshire, Your Vision Insurance may be continued if it ends because Your employment ends unless:

- Your employment ends due to Your 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 You belong;
- You are entitled to enroll in Medicare; or
- Your Vision Insurance ends because You failed to pay the required premium.

The Employer must give You written notice of:

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

The premium that You must pay for Your continued Vision Insurance may include:

- any amount that You contributed for Your 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 Your Vision Insurance, You must:

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

The maximum continuation period will be the longest of:

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

Your 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 You belong;
- the date You are entitled to enroll for Medicare;
- if You do not pay the required premium to continue Your Vision Insurance; or
- the date You become eligible for coverage under any other group vision coverage.

## **NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)**

### **CONTINUATION OF YOUR DEPENDENT'S VISION INSURANCE**

If You are a resident of New Hampshire, Your Vision Insurance for Your Dependents may be continued if it ends because Your employment ends, Your marriage ends in divorce or separation, or You die, unless:

- Your employment ends due to Your gross misconduct;
- this Vision Insurance ends for all Dependents;
- this Vision Insurance is changed, for the class of employees to which You belong, to end Vision Insurance for Dependents;
- the Dependent is entitled to enroll in Medicare; or
- Your Vision Insurance for Your Dependents ends because You fail to pay a required premium.

If Vision Insurance for Your Dependents ends because Your 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 You and Your divorced or separated Spouse share responsibility for payment of the premium for continued Vision Insurance, both You and Your divorced or separated Spouse must provide the notification.

The Employer must give You, or Your former Spouse if You have died or Your marriage has ended, written notice of:

- Your right to continue Your Vision Insurance for Your Dependents;
- the amount of premium payment that is required to continue Your Vision Insurance for Your Dependents;
- the manner in which You or Your former Spouse must request to continue Your Vision Insurance for Your Dependents and pay premiums; and
- the date by which premium payments will be due.

The premium that You or Your former Spouse must pay for continued Vision Insurance for Your Dependents may include:

- any amount that You contributed for Your Vision Insurance before it ended; and
- any amount the Employer paid.

To continue Vision Insurance for Your Dependents, You or Your former Spouse must:

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

If You, and Your former Spouse, if applicable, fail to provide any required notification, or fail to request to continue Vision Insurance for Your Dependents and pay the first premium within the time limits stated in this section, Your right to continue Vision Insurance for Your Dependents will end.

## NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

### CONTINUATION OF YOUR DEPENDENT'S VISION INSURANCE (continued)

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

- 36 months if Vision Insurance for Your Dependents ends because Your marriage ends in divorce or separation, except that with respect to a Spouse who is age 55 or older when your marriage ends in divorce or separation the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group plan;
- 36 months if Vision Insurance for Your Dependents ends because You die, except that with respect to a Spouse who is age 55 or older when You die, the maximum continuation period will end when Your surviving Spouse becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months if Vision Insurance for Your Dependents ends because You become entitled to benefits under Title XVIII of Social Security, except that with respect to a Spouse who is age 55 or older when You become entitled to benefits under Title XVIII of Social Security, the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group vision coverage;
- 36 months if You become entitled to benefits under Title XVIII of Social Security while You are already receiving continued benefits under this section, except that with respect to a Spouse who is age 55 or older when You first become entitled to continue Your Vision Insurance the maximum continuation period will end when the divorced or separated Spouse 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 Your employment ends because You retire, and within 12 months of retirement You have 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 Your Dependents ends because Your employment ends, and within 60 days of the date Your employment ends you become entitled to disability benefits under Social Security; or
- 18 months if Vision Insurance for Your Dependents ends because Your 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 You belong;
- the date the Dependent becomes entitled to enroll for Medicare;
- if You do not pay a required premium to continue Vision Insurance for Your Dependents; or
- the date the Dependent becomes eligible for coverage under any other group vision coverage.

## **NOTICE FOR RESIDENTS OF NORTH CAROLINA**

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

(1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND

(2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

## NOTICE FOR RESIDENTS OF NEW MEXICO

### Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You 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 Date Insurance For Your Dependents Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR 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 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.

The basic protections provided by the Association are:

- Life Insurance
  - \$500,000 in death benefits
  - \$200,000 in cash surrender or withdrawal values
- Health Insurance
  - \$500,000 in hospital, medical and surgical insurance benefits
  - \$500,000 in long-term care insurance benefits
  - \$500,000 in disability income insurance benefits
  - \$500,000 in other types of health insurance benefits
- Annuities
  - \$250,000 in withdrawal and cash 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 hospital, medical and surgical insurance benefits.

**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. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at [www.utlifega.org](http://www.utlifega.org) or contact:

Utah Life and Health Insurance Guaranty Assoc.  
60 East South Temple, Suite 500  
Salt Lake City UT 84111  
(801) 320-9955

Utah Insurance Department  
3110 State Office Building  
Salt Lake City UT 84114-6901  
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.



## CIVIL UNION NOTICE FOR RESIDENTS OF VERMONT

Vermont law provides that the following definitions apply to your certificate:

- Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a Civil Union established according to Vermont law.
- Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a Civil Union established according to Vermont law.
- Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a Civil Union established according to Vermont law.
- "Dependent" includes a spouse, a party to a Civil Union established according to Vermont law, and a child or children (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.
- "Child" includes a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.
- "Civil Union" means a civil union established pursuant to Act 91 of the 2000 Vermont Legislative Session, entitled "Act Relating to Civil Unions".

All references in this notice to Civil Unions are limited to Civil Unions in which the parties are residents of Vermont.

If dependent insurance for a spouse and/or child is not provided under your certificate, such insurance is not added by virtue of this notice.

For purposes of dependent insurance, any person who meets the definition of "dependent" as set forth in this notice is required to meet all other applicable requirements in order to qualify for such insurance.

This notice does not limit any definitions or terms included in your certificate. It broadens definitions and terms only to the extent required by Vermont law.

### **DISCLOSURE:**

Vermont law grants parties to a Civil Union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to life and health insurance that are available to married persons under federal law may not be available to parties to a Civil Union. For example, a federal law, the Employee Retirement Income Security Act of 1974 known as "ERISA", controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a Civil Union in an ERISA employee benefit plan. However, governmental employers (not federal government) are required to provide life and health benefits to the dependents of a party to a Civil Union if the public employer provides such benefits to dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of insurance premiums. As a result, parties to a Civil Union and their families may or may not have access to certain benefits under this notice and the certificate to which it is attached that derive from federal law. You are advised to seek expert advice to determine your rights under this notice and the certificate to which it is attached.

# NOTICE FOR RESIDENTS OF VIRGINIA

## IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You 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, You may call Claims Customer Service at:  
1-855-METEYE1

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

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](http://www.scc.virginia.gov) - web address  
[ombudsman@scc.virginia.gov](mailto: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](mailto:MCHIP@vdh.virginia.gov)

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

## 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.

## NOTICE FOR RESIDENTS OF VIRGINIA (continued)

**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 THE STATE OF WASHINGTON

Washington law provides that the following apply to Your certificate:

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

**Domestic Partner** means each of two people, one of whom is an Employee of the Employer, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

## **NOTICE FOR RESIDENTS OF WEST VIRGINIA**

### **FREE LOOK PERIOD:**

If You are not satisfied with Your certificate, You may return it to Us within 10 days after You receive it, unless a claim has previously been received by Us under Your certificate. We will refund within 10 days of our receipt of the returned certificate 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.

## NOTICE FOR RESIDENTS OF WISCONSIN

### **KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**

**PROBLEMS WITH YOUR INSURANCE?** - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

MetLife  
Attn: Corporate Consumer Relations Department  
P.O. Box 997100  
Sacramento, CA 95899-7100  
1-800-638-5433

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

# **NOTICE FOR RESIDENTS OF ALASKA, LOUISIANA, MINNESOTA, MONTANA, NEW HAMPSHIRE, NEW MEXICO, UTAH AND WASHINGTON**

## **The Definition of Child In The Definitions Section Of This Certificate Is Modified For The Coverage 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 Your grandchildren residing with You. 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. Your natural child, adopted child, stepchild or grandchild under age 21 will not need to be supported by You to qualify as a Child under this insurance.

### **For Minnesota Residents (Vision Insurance):**

The term also includes

- Your grandchildren who are financially dependent upon You and reside with You continuously from birth;
- children for whom You or Your Spouse is the legally appointed guardian; and
- children for whom You have initiated 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. Your natural child, adopted child, stepchild, or children for whom You or Your Spouse is the legally appointed guardian under age 25 will not need to be supported by You 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, 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.

### **For New Mexico 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. Your 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 Your dependent on Your federal income tax return; or
- that child does not reside with You.

## **NOTICE FOR RESIDENTS OF ALASKA, LOUISIANA, MINNESOTA, MONTANA, NEW HAMPSHIRE, NEW MEXICO, UTAH AND WASHINGTON**

### **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. 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. 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
- You enroll 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.

### **For Washington 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.



# **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.

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## 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

#### Provider Network

#### Vision PPO Network

#### Vision Insurance For You and Your Dependents

#### For All Active Full-Time Employees who elect the High Option Vision Plan

Service Interval (months)	Exam	Lenses*	Frame*	Contacts*
	12 months	12 months	12 months	12 months

<b>Exam In-Network Co-Payment</b> <i>Co-Payment shall not apply to Retinal Imaging</i>	\$10
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<b>Materials In-Network Co-Payment</b> <i>Co-Payment shall not apply to Elective Contact Lenses</i>	\$10
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	In-Network Coverage (Using an In-Network Vision Provider)	Out-of-Network Coverage (Using an Out-of-Network Vision Provider)
<b>EYE EXAMINATION</b>  (one per frequency)	Covered in full after any applicable Co-Payment  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.

<b>RETINAL IMAGING</b>	Covered in full with a Co-Payment not to exceed \$39.  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
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<b>STANDARD CORRECTIVE LENSES</b>	Single Vision Covered in full after any applicable Co-Payment	Covered up to \$30 allowance
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**SCHEDULE OF BENEFITS (continued)**

	Lined Bifocal Covered in full after any applicable Co-Payment	Covered up to \$50 allowance
	Lined Trifocal Covered in full after any applicable Co-Payment	Covered up to \$65 allowance
	Lenticular Covered in full after any applicable Co-Payment	Covered up to \$100 allowance

<b>STANDARD LENS OPTIONS<sup>1</sup></b>	Ultra Violet Coating Covered in full after any applicable Co-Payment	Applied to the allowance for the applicable corrective lens
	Standard Polycarbonate (child up to age 18) Covered in full after any applicable Co-Payment	Applied to the allowance for the applicable corrective lens
	Standard Progressive Covered in full after any applicable Co-Payment  Premium Progressive  This lens option is available at a discount with "not to exceed" pricing/maximum member out of pocket amount. <sup>1</sup>	Standard Progressive \$50 allowance; or  Premium Progressive \$50 allowance
	Standard Polycarbonate (adult) Covered in full after any applicable Co-Payment	Applied to the allowance for the applicable corrective lens
	Scratch Resistant Coating Covered in full after any applicable Co-Payment	Applied to the allowance for the applicable corrective lens
	Tints  This lens option is available at a discount with "not to exceed" pricing/maximum member out of pocket amount. <sup>1</sup>	Applied to the allowance for the applicable corrective lens

**SCHEDULE OF BENEFITS (continued)**

	<p>Anti-Reflective Coating</p> <p>This lens option is available at a discount with "not to exceed" pricing/maximum member out of pocket amount.<sup>1</sup></p>	<p>Applied to the allowance for the applicable corrective lens</p>
	<p>Photochromic</p> <p>This lens option is available at a discount with "not to exceed" pricing/maximum member out of pocket amount.<sup>1</sup></p>	<p>Applied to the allowance for the applicable corrective lens</p>
<b>FRAMES</b>	<p>Covered up to a \$150 allowance less any applicable Co-Payment.</p> <p>Frames are covered up to the allowance of \$85 less any applicable Co-Payment. at Costco, Walmart and Sam's Club and \$150 less any applicable Co-Payment. at other optical retail locations.</p>	<p>Covered up to a \$70 allowance</p>
<b>CONTACT LENSES</b>	<b>In-Network Coverage (Using an In-Network Vision Provider)</b>	<b>Out-of-Network Coverage (Using an Out-of-Network Vision Provider)</b>
<b>FITTING AND EVALUATION</b>	<p><b>Standard and Premium fit:</b></p> <p>Covered in full with a Co-Payment not to exceed \$60.</p>	<p>Applied to the allowance for the contact lenses</p>
<b>ELECTIVE</b>	<p>Covered up to \$150 allowance</p> <p>Contact lenses are provided in place of lens and frame benefits available herein.</p>	<p>Covered up to \$105 allowance</p> <p>Contact lenses are provided in place of lens and frame benefits available herein.</p>
<b>NECESSARY</b>	<p>Covered in full after any applicable Co-Payment</p> <p>Necessary contact lenses are a Plan Benefit when specific criteria are satisfied and when prescribed by Covered Person's In-Network Vision Provider.</p> <p>Contact lenses are provided in place of lens and frame benefits available herein.</p>	<p>Covered up to \$210 allowance</p> <p>Necessary contact lenses are a Plan Benefit when specific criteria are satisfied and when prescribed by Covered Person's In-Network Vision Provider.</p> <p>Contact lenses are provided in place of lens and frame benefits available herein.</p>

## SCHEDULE OF BENEFITS (continued)

SUPPLEMENTAL PLAN BENEFITS	In-Network Coverage (Using an In-Network Vision Provider)	Out-of-Network Coverage (Using an Out-of-Network Vision Provider)
<b>SECOND PAIR</b>	<p>This benefit gives you additional eyewear coverage. You can get:</p> <ul style="list-style-type: none"> <li>• Two pairs of prescription eyeglasses; or</li> <li>• One pair of prescription eyeglasses and an allowance toward contact lenses, or</li> <li>• Double your contact lens allowance.</li> </ul>	<p>Service intervals are the same as shown at left for In-Network Coverage.</p> <p>Benefits payable are the same as the primary plan benefits up to the Out-of-Network exam and materials allowances stated above.</p>

<sup>1</sup>All lens enhancements are available at participating private practice provider offices, 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 enhancements 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 enhancements and pricing prior to receiving services.

<b>Value-Added Features Available At In-Network Vision Providers (These features are not insurance.)</b>	
<b>REFRACTIVE SURGERY DISCOUNT</b>	Savings averaging 15% off the regular price, or 5% off a promotional offer, for Refractive Surgery.
<b>ADDITIONAL SAVINGS ON GLASSES AND SUNGLASSES</b>	20% savings on additional pairs of prescription glasses and nonprescription sunglasses, including lens enhancements. <sup>2</sup> At times, other promotional offers may also be available.
<b>ADDITIONAL SAVINGS ON LENS ENHANCEMENTS</b>	Average 20-25% savings on all lens enhancements not otherwise covered under the MetLife Vision Insurance program. <sup>2</sup>
<b>ADDITIONAL SAVINGS ON FRAMES</b>	20% off any amount over your frames allowance. <sup>2</sup>
<b>ADDITIONAL ALLOWANCE ON FEATURED FRAMES</b>	For certain frames, an additional \$20 allowance. <sup>2</sup>

<sup>2</sup> These features may not be available in all states and with all In-Network Vision Providers. Please check with Your In-Network Vision Provider.

## 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 basis. This must be done at:

- the Participating Employer's place of business;
- an alternate place approved by the Participating Employer; or
- a location to which the Participating Employer's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Participating Employer-approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

**Child** means the following: (for residents of Louisiana, Minnesota, Montana, New Hampshire, New Mexico, Utah and Washington, the Child Definition is modified as explained in the Notice pages of this certificate - please consult the Notice)

For Vision Insurance, Your natural or adopted child; Your stepchild; or a child who resides with and is fully supported by You; and who, in each case, is under age 26. The term also includes Your grandchild who is under age 26, and who was able to be claimed by You as a Dependent for Federal Income Tax purposes at the time You applied for Vision Insurance.

A child will be considered Your adopted child during the period You are party to a suit in which You are seeking the adoption of the child.

If You provide Us notice, a Child also includes a child for whom You must provide Vision Insurance due to a Qualified Medical Child Support Order as defined in the United States Employee Retirement Income Security Act of 1974 as amended.

The term includes an Employee's Child who is incapable of self-sustaining employment because of a mental or physical disability as defined by applicable law, and has been so disabled continuously since a date before the Child reached the limiting age and who otherwise qualifies as a Child except for the age limit.

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.

**Contributory Insurance** means insurance for which the Participating Employer requires You to pay any part of the premium.

Contributory Insurance includes: Vision Insurance for You and Your Dependents.

**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.

**Dependent(s)** means Your Spouse and/or Child.

**Full-Time** means Active Work on the Participating Employer's regular work schedule for the class of employees to which You belong. The work schedule must be at least 15.0 hours a week. Full-Time does not include temporary or seasonal employees.

**Noncontributory Insurance** means insurance for which the Participating Employer does not require You to

## **DEFINITIONS (continued)**

pay any part of the premium.

**Participant or Participating Employer** means an independent school district/political subdivision that has been accepted /approved for participation in the East Texas Employee Benefits Cooperative.

**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.

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.

**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** 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.



## DEFINITIONS

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

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

**Covered Services and Materials** means 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, VISION INSURANCE or VISION INSURANCE: DESCRIPTION OF COVERED SERVICES AND MATERIALS sections of this certificate.

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.

**In-Network Vision Provider** means an optometrist, therapeutic, optometrist, ophthalmologist, or optician

**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.

**Out-of-Network Vision Provider/Non-Network Vision Provider** means any optometrist, therapeutic, 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.

**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.

**Service Interval or Frequency** means a period of consecutive months, as shown in the SCHEDULE OF BENEFITS, in which You or Your Dependent may receive Covered Services and Materials. This period starts on Your or Your Dependent'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.

## **DEFINITIONS (continued)**

**Vision Provider** means an eye care professional who is an optometrist, therapeutic, 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; and

### **The term does not include:**

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's:
  - parents;
  - children (natural, step or adopted);
  - siblings;
  - grandparents; or
  - grandchildren.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU**

### **ELIGIBLE CLASS(ES)**

**All Active Full-Time Employees who elect the High Option Vision Plan**

### **DATE YOU ARE ELIGIBLE FOR INSURANCE**

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

#### **For All Active Full-Time Employees who elect the High Option Vision Plan**

If You are in an eligible class on September 1, 2022, You will be eligible for insurance on that date.

If You enter an eligible class after September 1, 2022, You will be eligible for insurance on the first day of the month following the date You enter that class.

**Waiting Period** means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

### **ENROLLMENT PROCESS FOR VISION INSURANCE**

If You are eligible for insurance, You may enroll for such insurance by completing the required form in Writing. If You enroll for Contributory Insurance, You must also give the Employer Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Employer how much You will be required to contribute.

The Vision Insurance has a regular enrollment period established by the Employer. Subject to the rules of the Group Policy, You may enroll for Vision Insurance only when You are first eligible or during an annual enrollment period or if You have a Qualifying Event. You should contact the Employer for more information regarding the annual enrollment period.

### **DATE YOUR INSURANCE TAKES EFFECT**

#### **Enrollment When First Eligible**

If You complete the enrollment process within 31 days of becoming eligible for insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the insurance would otherwise take effect, the benefit will take effect on the day You resume Active Work.

#### **If You Do Not Enroll When First Eligible**

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for Vision Insurance until the next annual enrollment period, as determined by the Employer, following the date You first become eligible or if You have a Qualifying Event. At that time You will be able to enroll for insurance for which You are then eligible.

#### **Enrollment During An Annual Enrollment Period**

During any annual enrollment period as determined by the Employer, You may enroll for vision insurance for which You are eligible. The changes to Your insurance made during an annual enrollment period will take effect on the first day of the month following the enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU**

### **Enrollment During Any Subsequent Vision Enrollment Period**

During any subsequent annual enrollment period for vision insurance as determined by the Employer, You may choose a different option than the one for which You are currently enrolled. If You make changes to Your insurance during a subsequent enrollment period, the change will also apply to the level of your Dependent Vision Insurance. The Vision Insurance takes effect on the first day of the month following the enrollment period, if You are Actively at Work on that day.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

### **Enrollment Due to a Qualifying Event**

You may enroll for insurance for which You are eligible or change the amount of Your insurance between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the month coincident with or next following the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

**Qualifying Event** includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- You previously did not enroll for vision coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to loss of eligibility for the other group coverage; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

### **DATE YOUR INSURANCE ENDS**

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the end of the period for which the last premium has been paid for You;
4. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT;
5. the last day of the calendar month in which You retire in accordance with the Employer's retirement plan; or
6. the date You are no longer a Participant or Participating Employer in good standing with the East Texas Employee Benefits Cooperative.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS**

### **ELIGIBLE CLASS(ES)**

**All Active Full-Time Employees who elect the High Option Vision Plan**

### **DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE**

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

#### **For All Active Full-Time Employees who elect the High Option Vision Plan**

If You are in an eligible class on September 1, 2022, You will be eligible for Dependent insurance on that date.

If You enter an eligible class after September 1, 2022, You will be eligible for Dependent insurance on the first day of the month following the date You enter that class.

**Waiting Period** means the period of continuous membership in an eligible class that You must wait before You become eligible for Dependent insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

No person may be insured as a Dependent of more than one employee.

### **ENROLLMENT PROCESS FOR DEPENDENT VISION INSURANCE**

If You are eligible for Dependent insurance, You may enroll for such insurance by completing the required form in Writing. If You enroll for Contributory Insurance, You must also give the Employer Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Employer how much You will be required to contribute.

In order to enroll for Vision Insurance for Your Dependents, You must either (a) already be enrolled for Vision Insurance for You or (b) enroll at the same time for Vision Insurance for You.

The Vision Insurance has a regular enrollment period established by the Employer. Subject to the rules of the Group Policy, You may enroll for Vision Insurance only when You are first eligible or during an annual enrollment period or if You have a Qualifying Event. You should contact the Employer for more information regarding the annual enrollment period.

### **DATE YOUR INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS**

#### **Enrollment When First Eligible**

If You complete the enrollment process within 31 days of becoming eligible for Dependent Insurance, such insurance will take effect on the later of:

- the date You become eligible for such insurance; and
- the date You enroll

provided You are Actively at Work on that date. If You are not Actively at Work on the date the insurance would otherwise take effect, the benefit will take effect on the day You resume Active Work.

#### **If You Do Not Enroll When First Eligible**

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for Dependent Vision Insurance until the next annual enrollment period, as determined by the Employer, following the date You first become eligible or if You have a Qualifying Event. At that time You will be able to enroll for insurance for which You are then eligible.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)**

### **Enrollment During An Annual Enrollment Period**

During any annual enrollment period as determined by the Employer, You may enroll for Dependent vision insurance for which You are eligible. The changes to Your Dependent insurance made during an annual enrollment period will take effect on the first day of the month following the enrollment period, if You are Actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

### **Enrollment During Any Subsequent Vision Enrollment Period**

During any subsequent annual enrollment period for vision insurance as determined by the Employer, You may choose a different option than the one for which You are currently enrolled. If You make changes to Your insurance during a subsequent enrollment period, the change will also apply to the level of your Dependent Vision Insurance. The Vision Insurance takes effect on the first day of the month following the enrollment period, if You are Actively at Work on that day.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

### **Enrollment Due to a Qualifying Event**

You may enroll for Dependent insurance for which You are eligible or change the amount of Your Dependent insurance between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 31 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the month coincident with or next following the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

**Qualifying Event** includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- You previously did not enroll for vision coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to loss of eligibility for the other group coverage; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

### **DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS**

A Dependent's insurance will end on the earliest of:

1. the date Your Vision Insurance ends;
2. the date You die;
3. the date the Group Policy ends;
4. the date Insurance for Your Dependents ends under the Group Policy;
5. the date Insurance for Your Dependents ends for Your class;
6. the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS**

7. the end of the period for which the last premium has been paid;
8. the date the person ceases to be a Dependent;
9. for Utah residents, the last day of the calendar month the person ceases to be a Dependent;
10. the last day of the calendar month in which You retire in accordance with the Employer's retirement plan;  
or
11. the date You are no longer a Participant or Participating Employer in good standing with the East Texas Employee Benefits Cooperative.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT**

### **FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN**

Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 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 mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

### **FOR FAMILY AND MEDICAL LEAVE**

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Employer for information regarding such legally mandated leave of absence laws.

### **COBRA CONTINUATION FOR VISION INSURANCE**

**The following applies to employers with 20 or more employees that are not church or government plans:**

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 the Employer for information regarding continuation of insurance under COBRA.

### **AT THE PARTICIPATING EMPLOYER'S OPTION**

The Participating Employer has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below. If Your insurance is continued, insurance for Your Dependents may also be continued. You will be notified by the Employer how much You will be required to contribute.

Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to layoff up to 2 months.
2. for the period You cease Active Work in an eligible class due to injury or sickness up to 9 months.
3. for the period You cease Active Work in an eligible class due to any other Employer approved leave of absence up to 2 months.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

If Your insurance ends, Your Dependents' insurance will also end in accordance with the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS.



## **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 1-855-METEYE1 or by visiting Our website at [www.metlife.com/mybenefits](http://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.

## **VISION INSURANCE (continued)**

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  $\pm 10.00$  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, if indicated as a Covered Service on the SCHEDULE OF BENEFITS. Dilation is included as a Covered Service when provided by an In-Network Vision Provider.
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;
  - 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  $\pm .50$  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 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 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, 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; 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, except for emergency vision care.
20. Services, procedures, or materials for which a charge would not have been made in the absence of insurance.

## VISION INSURANCE: COORDINATION OF BENEFITS

When You or a Dependent incur charges for Covered Services and Materials, there may be other Plans, as defined below, that also provide benefits for those same charges. In that case, We may reduce what We pay based on what the other Plans pay. This Coordination of Benefits section explains how and when We do this.

### DEFINITIONS

In this section, the terms set forth below have the following meanings:

**Allowable Expense** means a necessary vision expense for which both of the following are true:

- a Covered Person must pay it, and
- it is at least partly covered by one or more of the Plans that provide benefits to the Covered Person.

If a Plan provides fixed benefits for specified events or conditions (instead of benefits based on expenses incurred) such benefits are Allowable Expenses.

If a Plan provides benefits in the form of services, We treat the reasonable cash value of each service performed as both an Allowable Expense and a benefit paid by that Plan.

#### **The term does not include:**

- expenses for services performed because of a Job-Related Injury or Sickness;
- any amount of expenses in excess of the higher reasonable and customary fee for a service, if two or more Plans compute their benefit payments on the basis of reasonable and customary fees;
- any amount of expenses in excess of the higher negotiated fee for a service, if two or more Plans compute their benefit payments on the basis of negotiated fees;] and
- any amount of benefits that a Primary Plan does not pay because the covered person fails to comply with the Primary Plan's managed care or utilization review provisions, these include provisions requiring:
  - second surgical opinions;
  - preauthorization of services;
  - use of providers in a Plan's network of providers; or
  - any other similar provisions.

If You or a Dependent are also covered under an HMO plan, we will not use this provision to refuse to pay benefits because an HMO member has elected to have vision services provided by a non-HMO provider and the HMO's contract does not require the HMO to pay for providing those services.

**Claim Determination Period** means a calendar year or plan year. A Claim Determination Period for any Covered Person will not include periods of time during which that person is not covered under This Plan.

**Custodial Parent** means a Parent awarded custody, other than joint custody, by a court decree. In the absence of a court decree, it means the Parent with whom the child resides more than half of the Year without regard to any temporary visitation.

**HMO** means a Health Maintenance Organization or Vision Health Maintenance Organization.

**Job-Related Injury or Sickness** means any injury or sickness:

- for which You are entitled to benefits under a workers' compensation or similar law, or
- any arrangement that provides for similar compensation; or arising out of employment for wage or profit.

**Parent** means a person who covers a child as a dependent under a Plan.

## **VISION INSURANCE: COORDINATION OF BENEFITS (continued)**

**Plan** means any of the following if it provides benefits or services for an Allowable Expense:

- a group insurance plan;
- an HMO;
- a blanket plan;
- uninsured arrangements of group or group type coverage;
- a group practice plan;
- a group service plan;
- a group prepayment plan;
- any other plan that covers people as a group;
- any other coverage required or provided by any law or any governmental program, except Medicaid.

**The term does not include any of the following:**

- individual or family insurance or subscriber contracts;
- individual or family coverage through closed panel Plans or other prepayment, group practice or individual practice Plans;
- hospital indemnity coverage;
- a school blanket plan that only provides accident-type coverage on a 24 hour basis, or a "to and from school basis," to students in a grammar school, high school or college;
- disability income protection coverage;
- accident only coverage;
- specified disease or specified accident coverage;
- nursing home or long term care coverage; or
- any government program or coverage if, by state or Federal law, its benefits are excess to those of any private insurance plan or other non-government plan.

The provisions of This Plan which limit benefits based on benefits or services provided under:

- Government Plans; or
- Plans which the employer, Policyholder (or an affiliate) contributes to or sponsors;

will not be affected by these Coordination of Benefits provisions.

## VISION INSURANCE: COORDINATION OF BENEFITS (continued)

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not. [If two people are both insured under This Plan as employees, each person's insurance will be treated as a separate Plan.

**This Plan** means the vision benefits described in this certificate, except for any provisions in this certificate that limit insurance based on benefits for services provided under government plans, or plans which the employer (or an affiliate) contributes to or sponsors.

**Primary Plan** means a Plan that pays its benefits first under the "Rules to Decide Which Plan Is Primary" section. A Primary Plan pays benefits as if the Secondary Plans do not exist.

**Secondary Plan** means a Plan that is not a Primary Plan. A Secondary Plan may reduce its benefits by amounts payable by the Primary Plan. If there are more than two Plans that provide coverage, a Plan may be Primary to some plans, and Secondary to others.

### RULES TO DECIDE WHICH PLAN IS PRIMARY

When more than one Plan covers the person for whom Allowable Expenses were incurred, We determine which plan is primary by applying the rules in this section.

When there is a basis for claim under This Plan and another Plan, This Plan is Secondary unless:

- the other Plan has rules coordinating its benefits with those of This Plan; and
- This Plan is primary under This Plan's rules.

The first rule below which will allow Us to determine which Plan is Primary is the rule that We will use.

**Dependent or Non-Dependent:** A Plan that covers a person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is Primary and shall pay its benefits before a Plan that covers the person as a dependent; except that if the person is a Medicare beneficiary and, as a result of federal law or regulations, 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 and the Plan that covers the person as a dependent is Primary.

## **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 1-855-METEYE1. Vision claim forms can also be downloaded from [www.metlife.com/mybenefits](http://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 90 days from the date of service.

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](http://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 90 days from the date of service. If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible.



## 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. You have the right to seek review by an independent review organization in the case the initial appeal is denied.

**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 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, may be 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.

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.

### **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.

**THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.  
THE FOLLOWING IS ADDITIONAL INFORMATION.**



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

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## **Our Privacy Notice**

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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.

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### **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, or as an executive benefit. In this notice, “you” refers to these individuals.

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### **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.

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### **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.

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### **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, Inc. (“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, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at [www.mib.com](http://www.mib.com).

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## **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

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## **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

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## **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](http://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](mailto:HIPAAprivacyAmericasUS@metlife.com), or call us at telephone number (212) 578-0299.

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## **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.

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**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](mailto: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.

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## 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](http://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 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.

- **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 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

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.

### **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

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 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

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**

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

- **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](mailto: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.

**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](mailto: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

## **PLAN PRIVACY INFORMATION**

**Notwithstanding any other Plan provision in this or other sections of the Plan, the Plan will operate in accordance with the HIPAA privacy laws and regulations as set forth in 45 CFR Parts 160 and 164, and as they may be amended (“HIPAA”), with respect to protected health information (“PHI”) as that term is defined therein. The Plan Administrator and/or his or her designee retains full discretion in interpreting these rules and applying them to specific situations. All such decisions shall be given full deference unless the decision is determined to be arbitrary and capricious.**

**The term “Plan Sponsor” means East Texas Employee Benefits Cooperative.**

**The term “Plan Administrator” means the entity designated as Plan Administrator by the Plan documents pursuant to which the plan is operated. If a Plan Administrator is not designated by the plan documents, the Plan Sponsor shall be deemed to be the Plan Administrator.**

### **I. Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor**

The Plan and the Plan Sponsor are permitted to use and disclose PHI for the following purposes, to the extent they are not inconsistent with HIPAA:

- For general plan administration, including policyholder service functions, enrollment and eligibility functions, reporting functions, auditing functions, financial and billing functions, to assist in the administration of a consumer dispute or inquiry, and any other authorized insurance or benefit function.
- As required for computer programming, consulting or other work done in respect to the computer programs or systems utilized by the Plan.
- Other uses relating to plan administration, which are approved in writing by the Plan Administrator or Plan Privacy Officer.
- At the request of an individual, to assist in resolving an individual's benefit or claim issues.

### **II. Uses and Disclosures of PHI by the Plan and the Plan Sponsor for Required Purposes**

The Plan and Plan Sponsor may use or disclose PHI for the following required purposes:

- Judicial and administrative proceedings, in response to lawfully executed process, such as a court order or subpoena.
- For public health and health oversight activities, and other governmental activities accompanied by lawfully executed process.
- As otherwise may be required by law.

### **III. Sharing of PHI With the Plan Sponsor**

As a condition of the Plan Sponsor receiving PHI from the Plan, the Plan Documents have been amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan documents in Sections I and II above;

- Ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;
- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the Plan any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures of which it becomes aware;
- Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures required by HIPAA;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- Ensure adequate separation between the Plan and Plan Sponsor in accordance with the following requirements:
  - (A) Employees to be Given Access to PHI: The following employees (or class of employees) of the Plan Sponsor are the only individuals that may access PHI provided by the Plan:  
  
Customer Relations Specialist
  - (B) Restriction to Plan Administration Functions: The access to and use of PHI by the employees of the Plan Sponsor designated above will be limited to plan administration functions that the Plan Sponsor performs for the Plan.
  - (C) Mechanism for Resolving issues of Noncompliance: If the Plan Administrator or Privacy Officer determines that an employee of the Plan Sponsor designated above has acted in noncompliance with the plan document provisions outlined above, then the Plan Administrator or Privacy Officer shall take or seek to have taken appropriate disciplinary action with respect to that employee, up to and including termination of employment as appropriate. The Plan Administrator or Privacy Officer shall also document the facts of the violation, actions that have been taken to discipline the offending party and the steps taken to prevent future violations.
- Certify to the Plan, prior to the Plan permitting disclosure of PHI to the Plan Sponsor, that the Plan Documents have been amended to incorporate the provisions of this Section.

#### **IV. Participants Rights**

Participants and their covered dependents will have the rights set forth in the Plan's or its vision insurer's HIPAA Notice of Privacy Practices for Protected Health Information and any other rights and protections required under the HIPAA. The Notice may periodically be revised by the Plan or its vision insurer.

#### **V. Privacy Complaints/Issues**

All complaints or issues raised by Plan participants or their covered dependents in respect to the use of their PHI must be submitted in writing to the Plan Administrator. A response will be made within 30 days of the receipt of the written complaint. In the event more time is required to resolve any issues this period can be extended to 90 days. The affected participant must receive written notice of the extension and the resolution of their complaint. The Plan Administrator shall have full discretion in resolving the complaint and making any required interpretations and factual determinations. The decision of the Plan Administrator shall be final and be given full deference by all parties.

#### **VI. Security**

As a condition of the Plan Sponsor receiving electronic PHI ("ePHI") from the Plan, the Plan Documents have been amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and the Plan Sponsor, which is required by the applicable section(s) of the Plan relating to the sharing of PHI with the Plan Sponsor, is supported by reasonable and appropriate security measures;
- Ensure that any agent to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which it becomes aware. In this context, the term "security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in information systems such as hardware, software, information, data, applications, communications, and people.

## **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.

You 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.