Effective Plan Year 2025

Pediatric Vision Certificate of Insurance

UPMC Vision Care*
UPMC HEALTH BENEFITS, INC. (hereafter referred to as "UPMC Health Plan"[1] or "the Plan")
a Pennsylvania corporation whose address is
U.S. Steel Tower, 600 Grant Street, Pittsburgh, PA 15219

STUDENT GUARANTEED RENEWABLE/PREMIUM SUBJECT TO CHANGE

Welcome and General Information for Members

This document is your Pediatric Vision Certificate of Insurance ("Certificate"). If this Certificate has been purchased on behalf of a child, references to "you" or "your" should be considered to reference the child. Your Certificate establishes the terms of coverage only for this vision plan for those Members up to the age of 19. Your Certificate sets forth what services are covered and what services are not covered. It explains the procedures that you must follow to ensure that the vision services you receive will be covered under your vision plan. It also describes how you submit a claim, file a Complaint or appeal an Adverse Benefit Determination, and other information that you may need to know to access your vision benefits. The Certificate acts as a contract between you and the Plan, setting forth your obligations as a Member and our obligations as your vision benefits carrier.

It is important to use this Certificate along with your Pediatric Vision Schedule of Benefits. Your Pediatric Vision Schedule of Benefits is the document that outlines your coverage amount and Benefit Limits. Anything contained herein to the contrary notwithstanding, the Plan shall have the right, for the purpose of complying with the provisions of any law or any lawful order of a regulatory authority, to amend the Certificate or any attachment hereto or to increase, reduce, or eliminate any of the benefits provided in the Certificate for any one or more eligible Members enrolled under the Certificate, and each party hereby agrees to any amendment of the Certificate which is necessary in order to accomplish such purpose.

The vision coverage described in this document is deemed an essential health benefit (EHB) for Members up to the age of 19 who are enrolled in medical coverage and applies only to those Members who meet this criterion.

This Certificate does not divide or give back any excess premiums to its Members.

This Preferred Provider Organization (PPO) plan may not cover all of your vision expenses. Read this Certificate carefully to determine which vision services are covered.

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[1]UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC for You Inc. Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

Guaranteed renewable/Premium subject to change
UPMC Health Plan may adjust premiums after getting approval from the Pennsylvania Insurance Department. You will be notified in advance of any change in your premium. This Certificate will remain in effect each month as long as the applicable premiums are paid. UPMC Health Plan will not terminate your coverage because of the deterioration of your mental or physical health or that of any individual covered under this Certificate. This Certificate shall remain in effect continually unless terminated by UPMC Health Plan in accordance with the termination section under your medical Policy, you elect to disenroll in coverage, you fail to meet the eligibility requirements as determined by your school or university, or your school or university no longer contracts for coverage.

Health Care Concierge team
To help you get accurate answers to questions and up-to-date information about your vision program, please log in to the UPMC Health Plan member site via www.upmchealthplan.com, call 1-844-252-0687, or write to UPMC Health Plan, U.S. Steel Tower, 600 Grant Street, Pittsburgh, PA 15219. You can:

- Learn about UPMC Vision Care.
- Find Participating Vision Providers.
- Verify your eligibility.
- Request an Out-of-Network Vision Claim Form.
- Speak with our Health Care Concierge team.
- Ask questions about your vision care benefits.
- Initiate a Complaint regarding a Participating Vision Provider, or the coverage (including Certificate exclusions and noncovered benefits), operations, or management policies of this vision plan.
- Initiate an appeal of an Adverse Benefit Determination based solely on the Medical Necessity and appropriateness of a vision service.

Our Health Care Concierge team is available Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m. at 1-844-252-0687. Members who use a TTY (teletypewriter) may access TTY services by calling TTY: 711.

Helpful phone numbers:

- Member Health Care Concierge: 1-844-252-0687
- TTY Services: 711
- Provider Service: 1-877-262-7870
- Fraud and Abuse Special Investigation Unit: 1-866-FRAUD01 (1-866-372-8301)
- UPMC Fax: 1-888-830-5560

*UPMC Vision Care is a product of UPMC Health Benefits Inc. and is administered by National Vision Administrators (NVA).

Mary Beth Jenkins, President and CEO, UPMC Health Plan

Gordon Gebbens, Chief Financial Officer, UPMC Health Plan

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Terms and Definitions to Help You Understand Your Coverage

The following are some important, frequently used terms and definitions that the Plan uses in this Certificate and when administering your benefits.

Adverse Benefit Determination – Any of the following:

- A determination by UPMC Health Plan that a request for a benefit does not meet UPMC Health Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental/Investigational, such that the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit.
- UPMC Health Plan's denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination that you are ineligible for coverage, failed to submit complete information, or failed to comply with an administrative policy of UPMC Health Plan (Administrative Denials).
- A rescission of coverage determination by UPMC Health Plan (retroactive cancellation of your coverage due to fraud or intentional misrepresentation of a material fact).

Instructions regarding how to appeal an Adverse Benefit Determination are set forth in **Section VIII,** Resolving Disputes with UPMC Health Plan.

Appeal – A request for your Plan to review an Adverse Benefit Determination.

Benefit Limit – The maximum amount that the Plan will pay for a Covered Service. Some Benefit Limits are discussed in this Certificate, but generally Benefit Limits are set forth in your Pediatric Vision Schedule of Benefits.

Benefit Period – The specified period of time (for which you are eligible for coverage during your university/school's contract year) during which charges for Covered Services must be incurred in order to be eligible for payment by UPMC Health Plan. A charge shall be considered incurred on the date you receive the service or supply.

Complaint – A dispute or objection you lodge regarding a Participating Vision Provider or the coverage (including contract exclusions and noncovered benefits), operations, or management policies of this vision plan. Instructions on how to file a Complaint are set forth in the **Resolving Disputes with the Plan** section of this Certificate.

Copayment – The specified dollar amount that you pay at the time of service, for certain Covered Benefits. Copayments do not apply toward your coinsurance or deductible. You are expected to pay Copayments at the time of service. Refer to the Pediatric Vision Schedule of Benefits to determine Copayment amounts.

Covered Benefit or Covered Service – A service or supply that meets the requirements set forth in this Certificate.

Daily Wear Contact Lenses – Contact lenses that are approved and intended for wear during a single awake period of time, not to exceed the number of hours recommended by an eye care professional. Each day they are to be removed from the eye, cleaned, and sterilized. They are not intended for or approved for sleep.

Extended Wear (Planned Replacement/Frequent Replacement) Contact Lenses – Contact lenses that may be used for a specified period of time (daily, one week, two weeks, etc.), at which time they are discarded. In most cases they are removed, cleaned, and sterilized following wear. In some cases, they may be worn while sleeping, if approved by an eye care professional. Wearing schedules and duration of use must be as prescribed.

Medical Necessity or Medically Necessary – Health care services covered under your vision plan that

are determined by UPMC Health Plan to be:

- Commonly recognized throughout the provider's specialty as appropriate for the diagnosis and/or treatment of your condition, illness, disease, or injury.
- Provided in accordance with standards of good medical practice and consistent with scientifically based guidelines of medical, research, or health care coverage organizations or governmental agencies that are accepted by UPMC Health Plan.
- Reasonably expected to improve your condition or level of functioning and in conformity at the time of treatment with medical management criteria/guidelines adopted by UPMC Health Plan or its designee.
- Provided not only as a convenience or comfort measure or to improve physical appearance.
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service.

UPMC Health Plan reserves the right to determine whether a health care service meets these criteria.

Approval for coverage based on Medical Necessity shall be made by UPMC Health Plan, at its discretion, with input from the treating provider. Note that the fact that a provider orders, prescribes, recommends, or approves a health care service does not mean that the service is Medically Necessary or a Covered Benefit for purposes of coverage.

Member – An individual who is enrolled in and covered by this Certificate. References throughout this Certificate of Insurance to "you/your" refer to the Member.

National Vision Administrators (NVA®) – A third-party vision administrator that provides benefit programs and a provider network for UPMC Health Plan Members.

Nonparticipating Vision Laboratory – An optical laboratory that creates, promotes, sells, provides, advertises or administers vision care supplies that is not contracted with National Vision Administrators (**NVA®)**.

Nonparticipating Vision Provider – A vision provider who is not a contracted provider with the Plan.

Participating Vision Laboratory – An optical laboratory that has entered into an agreement with the Plan to render Covered Services to UPMC Health Plan Members through an arrangement with NVA.

Participating Vision Provider – A vision provider that has entered into an agreement with the Plan to render Covered Services to UPMC Health Plan Members. A Participating Vision Provider may also include participating providers that use an out-of-network vision laboratory.

Pediatric Vision Schedule of Benefits – List of Covered Services, Copayments, and limits.

Prior Authorization – The process in which UPMC Health Plan reviews all reasonably necessary supporting information prior to the delivery or provision of a requested service and makes a decision to approve or deny payment for the service based on whether the service is Medically Necessary. For certain treatment or services, you must obtain Prior Authorization prior to receiving the service by having your provider submit a Prior Authorization request that meets UPMC Health Plan's administrative requirements for such a request and includes the specific clinical information necessary to evaluate the request.
Proof of Loss – Documentation to support a claim.

Service Area – The Plan's primary Service Area, which consists of the counties listed in the most current version of the UPMC Health Plan provider directory. These are the counties in which UPMC Health Plan is licensed to do business and in which most of its Participating Vision Providers are located.

Specialty Contact Lenses – Lenses that require additional professional time in fitting and follow up care. These include rigid gas (O_2) permeable lenses, toric (correct for astigmatism) lenses, and multifocal lenses.

Usual, Customary, and Reasonable (UCR) – For the services authorized by UPMC Health Plan that are provided by a Participating or Nonparticipating Vision Provider, the UCR charge is the amount that UPMC Health Plan determines is reasonable for Covered Services pursuant to industry standards. Participating providers agreed to accept the UCR amount as payment in full. The Nonparticipating Vision Provider may charge you the difference between the billed amount and the UCR amount.

How the Vision Plan Works

Choosing a vision provider
You are enrolled in the UPMC Health Plan Preferred Provider Organization (PPO) vision plan administered by National Vision Administrators (NVA®). The coverage you receive under this Certificate is deemed an essential health benefit. Since you are enrolled in a PPO plan, you have the ability to self-direct your care. You have two levels of benefits. You can use Participating Vision Providers, also called in-network providers, for all Covered Services, as well as Nonparticipating Vision Providers, which are also called out-of-network providers, for most Covered Services. If you obtain services from Participating Vision Providers, you will receive the highest level of benefit coverage. If you obtain services from Nonparticipating Vision Providers, you will receive a lower level of benefit coverage. Be sure to read this Certificate to determine whether a service will be covered if obtained from a Nonparticipating Vision Provider.

Remember, if you use Nonparticipating Vision Providers, you may receive a lower level of benefit coverage, and you may be billed by those Nonparticipating Vision Providers for the difference between the vision provider's charges and the allowed amount. This means that because the Plan does not contract with a Nonparticipating Vision Provider, the vision provider can bill you for any amount over and above what the Plan covers. If a Participating Vision Provider chooses to recommend a Nonparticipating Vision Laboratory to dispense vision materials, the provider must provide written notification to you that indicates that the vision laboratory is not in-network and that you have the option to receive vision materials from an in-network vision laboratory prior to materials being ordered. You should not be charged for any services/materials covered by your plan unless otherwise indicated by your Schedule of Benefits.

To find a Participating Vision Provider, log in to the UPMC Health Plan member site at www.upmchealthplan.com or call our Health Care Concierge team at 1-844-252-0687 (TTY:711). When you visit the vision provider's office, let your vision provider know that you are covered under UPMC Health Plan. If your vision provider has questions about your eligibility or benefits, instruct the office to call 1-877-262-7870 or visit www.upmchealthplan.com/providers. The vision provider may use demographic information, such as your name and date of birth, to verify your eligibility and submit claims.

Relationship with providers
UPMC Health Plan recognizes the importance of maintaining the continuity of care rendered to you by your treating vision providers. Accordingly, to facilitate the management and quality of your overall treatment, the Plan may exchange information, including claims information, with your vision providers.

Remember, out-of-network providers do not have to comply with UPMC Health Plan policies and procedures. If you receive out-of-network services, you may be financially responsible for the difference between what UPMC Health Plan reimburses the Nonparticipating Vision Provider and the amount billed for the treatment and services.

The relationship between the Plan and Participating Vision Providers is that of independent contractors, and neither the Plan nor any Participating Vision Provider shall be considered an agent or representative of the other for any purpose.

The Plan makes no express or implied warranties or representations concerning the qualifications or continued participation of any Participating Vision Provider. The choice to use a particular provider is solely your own.

Participating Vision Providers may be terminated at the Plan's sole discretion. You may be required to choose another Participating Vision Provider if the provider rendering services to you terminates or is terminated from participation during the term of your enrollment, unless otherwise set forth herein or as required by state or federal law or regulation.

The Plan does not provide or render Covered Services. It only makes payment or provides coverage for those covered vision services you receive that are deemed necessary. Participating Vision Providers are solely responsible

for any vision services rendered to you and their other patients. The Plan is not liable for any act or omission of any provider that renders health care services to you. The Plan has no responsibility for a provider's failure or refusal to render health care services to you.

Out-of-network services
UPMC Health Plan encourages you to use Participating Vision Providers to maximize your benefit and minimize any out-of-network expenses. Participating Vision Providers can be located by visiting www.upmchealthplan.com, clicking on Find Care at the top of the page, and then selecting Vision.

In the event you select to have services performed by a Nonparticipating Vision Provider, UPMC Health Plan will reimburse you for eligible services up to the benefit maximum. You may download an Out-of-Network Claimform by logging in to the UPMC Health Plan member site via www.upmchealthplan.com or call our Health Care Concierge team at 1-844-252-0687 (TTY:711) to have a form sent to you.

For care outside of Pennsylvania
To locate a participating out-of-area provider, visit our website at www.upmchealthplan.com or call the Health Care Concierge team at 1-844-252-0687 (TTY:711) for assistance.

When using an out-of-area provider, identify yourself as a UPMC Health Plan Member, and the provider will verify eligibility and submit the claim on your behalf.

Remember, out-of-network providers do not have to comply with UPMC Health Plan policies and procedures. If you receive out-of-network services, you may be financially responsible for the difference between what UPMC Health Plan reimburses the Nonparticipating Vision Providers and the amount billed for the treatment and services.

Benefits

UPMC Health Plan provides coverage for the following vision services in accordance with UPMC Health Plan policies and procedures. Refer to your Pediatric Vision Schedule of Benefits for Copayment amounts as well as any Benefit Limits related to Covered Services. You may obtain Covered Services from either Participating or Nonparticipating Vision Providers and receive varying levels of coverage, as discussed throughout this Certificate. Remember that a statement from your vision provider saying he or she believes you should have certain services does not mean that those services are Covered Services for purposes of coverage under your vision plan.

Services
The general descriptions below explain the services on your Pediatric Vision Schedule of Benefits. The descriptions are *not* all-inclusive. They include only the most common vision procedures in a class or service grouping. Specific vision procedures may not be covered depending on your Plan. Refer to your Pediatric Vision Schedule of Benefits for Copayment amounts as well as any Benefit Limits related to Covered Services. Services covered in your Pediatric Vision Schedule of Benefits are also subject to the Schedule of Exclusions included in this document and in your Medical Policy. You may also log in to the UPMC Health Plan member site at www.upmchealthplan.com to check your coverage. Also, your vision provider may call UPMC Health Plan to verify coverage of specific vision procedures.

Vision Examinations: The comprehensive examination includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test), and dilation (if professionally indicated). Eligible members are entitled to have a vision examination once every 12 months:

- New patient
- Established patient
- Exams may not be available through some participating on-line retailers.

Lenses: Coverage is provided in full for standard polycarbonate eyeglass lenses. You are entitled to receive one pair of lenses once every 12 months. Options may include:

- Single vision
- Bifocal
- Trifocal
- Lens options may be available at an additional cost to you or may not be available when you receive them from a participating on-line retailers or out-of-network provider.

UPMC Health Plan provides discounted pricing on additional lens options, such as coatings, polarization, and other lens add-ons. A Copayment may apply for these additional services. Refer to your Pediatric Vision Schedule of Benefits and Additional Lens Options document for plan-specific benefit information.

Frames: Frames reimbursement is based on retail allowance and a percentage of the provider's agreed-upon reimbursement. Please refer to your Pediatric Vision Schedule of Benefits. You may select any frame from the Participating Vision Provider's inventory of collection frames, not exceeding $100, that are covered at 100 percent. Any frames not included in the collection and in excess of your plan allowance are your responsibility. A 20 percent discount may apply to amounts exceeding the plan and allowance and may vary by Participating Vision Provider. You are entitled to one frame once every 12 months.

Contact lenses (if deemed Medically Necessary): Medically Necessary contact lenses are covered at 100 percent with Prior Authorization when prescribed for a qualifying ocular condition. Contact lenses are only covered if they are deemed Medically Necessary by UPMC Health Plan, once every 12 months from the last date of service. This may include:

- A separate allowance for the fitting fee (standard or may apply after a comprehensive exam). The contact lens fitting fee is only covered under this Plan if you do not receive glasses.
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- Lens material
- Contact lenses may not be available when you receive them from a participating on-line retailer.

The contact lens benefit includes all types of contact lenses, such as hard, soft, gas permeable, and disposable lenses, in lieu of eyeglasses. UPMC Health Plan also offers Members an interim discount benefit through the NVA **EYEESSENTIAL® Plan**. Refer to your Pediatric Vision Schedule of Benefits plan documents for discounts on exams, lenses for eyeglasses, frames, and contact lenses. If you choose additional options not specified in your plan documents, you are responsible for the additional cost of the options to be paid directly to the provider. Not all providers participate in the discount plan. To locate a **provider that participates in the NVA EYEESSENTIAL® Plan, visit www.upmchealthplan.com** or call the Health Care Concierge team at 1-844-252-0687 (TTY: 711) for assistance.

Any add-ons or treatments not listed on your Pediatric Vision Schedule of Benefits, additional lens options, or NVA EYEESSENTIAL® documents are not covered by or to be billed to UPMC Health Plan.

Replacement eyeglass policy
If you require replacement of broken eyeglasses (frames and/or lenses), you may receive such replacement subject to approval by the Plan. The replacement frames and/or lenses are considered a lifetime benefit, payable once per eligible Member, and are available to you during the duration of your coverage. Replacements must be of the same frame (if still commercially available), lens type, material, and prescription. Only those parts (frame or lenses) requiring replacement will be replaced, and it may be necessary to return the frame to the laboratory to have the new lenses installed. Replacement eyeglasses will only be covered up to the plan maximum. Any costs exceeding the plan maximum, including the cost for replacing any lens options that may have originally been purchased, such as special coatings, progressive lenses, etc., will be your responsibility. Contact lenses are covered by the replacement policy. The replacement eyeglass policy applies to eyeglasses that are accidentally broken after you receive and accept them. In instances in which minor repairs may be made (for example missing nose pads or missing screws), you may be charged a $5 repair fee. The replacement and repair policy may not apply or vary when receiving services from a Nonparticipating Vision Laboratory. Please consult your vision provider regarding its replacement/repair policy.

UPMC Health Plan policy on nonadapts for Members with progressive addition lenses (PALS) and digital single vision lenses

On occasion, Members receiving PALS or certain types of digital single vision lenses experience difficulty in adapting to this new lens technology, even though the prescription is correct, and the Member is properly fitted. The vision industry considers this to be a "nonadapt" situation, for which the UPMC Health Plan Program provides protection in the form of the following warranty.

If you are unable to adapt to a PAL or digital single vision lens, you will be offered a replacement pair of conventional single vision, bifocal, or trifocal lenses in the same frame at no charge. The replacement lenses must be the same material and prescription as the original lenses and will include, at no additional charge, any lens options for which you previously paid a fee. Please note that any amount you paid for the original lenses is not refundable, so be sure that you discuss your visual needs and likelihood of success in wearing these lenses with your provider before placing your order.

This replacement policy is valid for up to 90 days from the receipt of your eyeglasses and may not apply when a Nonparticipating Vision Laboratory is used.

Pediatric Vision Schedule of Benefits

Your benefits are shown on the Pediatric Vision Schedule of Benefits included in this packet. The Pediatric Vision Schedule of Benefits shows:

- The classes of vision services covered, shown with the Usual, Customary, and Reasonable charges that the Plan pays for those services.
- Any of your out-of-pocket costs or cost sharing for a Covered Service.
- Any Copayments that must be paid per Benefit Period before any Covered Services will be paid by the Plan.
- Any limits for Covered Services for a given period of time; for example, annual limitations on lenses. Annual limits are applied on a Benefit Period basis.

Your out-of-pocket costs

In order to keep the plan affordable for you, the plan includes certain cost-sharing features. If the class or service grouping is not covered under the plan, the Pediatric Vision Schedule of Benefits will indicate "not covered." You will be responsible for paying your vision provider the full charges for services that are not Covered Services.

Exclusions

No benefits will be provided for services, supplies, or charges detailed in the Schedule of Exclusions.

Claims

Claims submissions

If you receive care from a Participating Vision Provider, you should not have to submit a claim to the Plan. The Participating Vision Provider will bill the Plan, and the Plan will pay the provider directly. However, if you obtain Covered Services from a Nonparticipating Vision Provider, you may have to file a claim yourself. To submit a claim, follow the steps below.

To obtain an Out-of-Network Vision Claimform, log in to the UPMC Health Plan member site via www.upmchealthplan.com or contact UPMC Health Plan at 1-844-252-0687 (TTY:711). Be sure to include the following information on the claim form:

- Your name
- Your date of birth
- The policyholder's member identification number
- The policyholder's name and address
- The name and policy number of a second insurer if you are covered by another vision plan
- Itemized statement or section two of the out of network claim form must be completed.
- Proof of payment (if you do not have proof of payment, you will need to include detailed information about the service provider name, address, date of service, and amount charged)

Claim forms should be sent to:

UPMC Health Plan P.O. Box 106039
Pittsburgh, PA 15230-6039

Remember, a request for payment of a claim will not be reviewed and no payment will be made unless all the information described above has been submitted to the Plan. The Plan reserves the right to require additional information and documents, if necessary, to support your claim. Should you have any questions concerning your coverage, eligibility, or a specific claim, contact UPMC Health Plan at 1-844-252-0687 (TTY:711) or log in to the UPMC Health Plan member site at www.upmchealthplan.com.

Notice of claim

The Plan will not be liable under this Certificate unless proper notice is furnished to the Plan that Covered Services in this Certificate have been rendered to you. Written notice must be given to the Plan within 20 days of the date in which the Covered Services were rendered or as soon as reasonably possible thereafter. You must give notice to the Plan in writing at UPMC Health Plan, P.O. Box 106039, Pittsburgh, PA 15230-6039. The notice must include the data necessary for the Plan to determine benefits such as the date of service, services rendered, provider name, office location, charges, etc. A charge shall be considered "incurred" on the date you receive the service or supply for which the charge is made.

Claim forms

Proof of Loss for benefits under this Certificate must be submitted to the Plan on the appropriate claim form. The Plan, upon receipt of notice of claim, will, within 15 days of the date the notice of a claim is received, furnish claim forms to you for filing Proofs of Loss. If claim forms are not furnished within 15 days after the giving of such notice, you shall be deemed to have complied with the requirements of this subsection as to filing a Proof of Loss upon submitting, within 90 days, itemized bills for Covered Services as described below. Proof of Loss may be submitted to the Plan at the claim address provided above.

Proof of Loss

Written Proof of Loss must be furnished to the Plan within 90 days after the date of such loss. Failure to give notice to the Plan within the time required will not reduce any benefit if it is shown that the notice was given

as soon as reasonably possible, but in no case, except in the absence of legal capacity, will the Plan be required to accept notice later than one year after the end date in which the Covered Service was rendered.

Timely payment of claims
Subject to due written Proof of Loss, all claims payable under this Certificate will be paid immediately, according to any applicable regulatory requirements. For submitted claims, the Plan will not be liable under this Certificate unless proper notice is furnished to the Plan that Covered Services have been rendered to you.

UPMC Health Plan will not be responsible for payment of claims for Covered Services that are submitted more than one year from the date of service.

Payment of claims
Claims payable under this Certificate when loss of life has occurred will be payable in accordance with the beneficiary designation and the provisions respecting such payment, which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, claims shall be payable to your estate. Any other accrued claims unpaid at your death may, at the option of the Plan, be paid either to such beneficiary or to such estate. All other claims will be payable to you.

Payment of benefits
If you have treatment performed by a Participating Vision Provider, we will pay Covered Benefits directly to the Participating Vision Provider. Payment will be based on the Usual, Customary, and Reasonable charges that the treating Participating Vision Provider has contracted to accept and what your vision benefit allows.

If you receive treatment from a Nonparticipating Vision Provider, we will send payment for Covered Benefits to you unless otherwise indicated on the claim form. Both you and the Nonparticipating Vision Provider will be notified of the Plan payment and any amounts you owe for charges exceeding your benefit limits or denial of noncovered services. The Plan payment will be based on the Usual, Customary, and Reasonable charge for the services. You will be responsible for paying the vision provider any difference between the Plan's payment and the vision provider's full charge for the service. Your right to reimbursement for any Covered Service is not assignable.

Change of beneficiary
The right to change of beneficiary is reserved for you, and the consent of the beneficiary or beneficiaries shall not be requisite to the surrender or assignment of this Certificate or to any change of beneficiary or beneficiaries, or to any other changes in this Certificate.

Overpayments
If we make an overpayment for benefits, we have the right to recover the overpayment. In the event that overpayment was made to you, we will recover the overpayment by requesting a refund. In the event that overpayment was made to the provider, we will recover the overpayment by either requesting a refund or offsetting the overpayment amount from future claim payments. Recovery will be done in accordance with any applicable state laws or regulations.

Coordination of Benefits
When you are eligible for coverage under more than one vision plan, the Plan will coordinate your benefits with those plans. The Plan does this to make sure that your benefits are paid appropriately while preventing duplicate payments. This is how coordination of benefits works for your benefit plan:

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits Paid or payable by that coverage will be taken into account when we determine if additional benefit payments can be made under this plan.

- When you are covered as an employee under one plan and as a dependent under another, the employee coverage pays first.

- When a dependent child is covered under two plans, the plan covering the parent whose birthday occurs earlier in the calendar year pays first. If both parents have the same birthday, then the plan under which one parent was covered longest pays first.

- If the dependent child's parents are separated or divorced and:
    - The parent with custody of the child has not remarried, the coverage of the parent with custody pays first.

    - The parent with custody has remarried, the coverage of the parent with custody pays first, but the stepparent's coverage, if any, pays before the coverage of the parent without custody.

    - There is a court order that specifies the parent who is financially responsible for the child's vision expenses, the coverage of that parent pays first.

- If the service is also covered under a medical plan in which you may be enrolled in, the medical plan pays first. If it is a covered vision benefit, vision coverage will be considered the secondary payer.

- When none of the above circumstances apply, the coverage that you have had the longest a will pay first, as long as:
    - The benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person; and

    - The other plan does not have a provision regarding laid-off or retired employees and, therefore, the benefits of each plan are determined after the other, then the provisions previously listed shall not apply.

If you or your vision provider receives more than you should have when your benefits are coordinated, you or your vision provider will be expected to repay the overpayment.

It is the policy of UPMC Health Plan to review all other insurance coverage before releasing a claim for payment. If other insurance coverage is found after a payment has been made, a review will determine which plan pays first and what action will be taken with regard to any claims in question. If payments should have been made by the Plan, but the payments were made under another benefit plan, UPMC Health Plan has the right to pay to the benefit plan that made the payment any amount that the Plan determines to be appropriate under the terms of this Certificate. Any amounts paid shall be considered to be benefits paid in full under this Certificate.

If the Plan makes a payment for Covered Services in excess of the amount of payment pursuant to this Certificate, irrespective of to whom those amounts were paid, UPMC Health Plan shall have the right to recover the excess amount from any person or entity to or for whom such payments were made. Upon reasonable request by the Plan or its agent, you must execute and deliver such documents as may be required and do whatever else is reasonably necessary to secure UPMC Health Plan's rights to recover the excess payments.

UPMC Health Plan is not required to determine whether or not you have other vision benefits or insurance or the amount of benefits payable under any other vision benefits or insurance. The Plan shall only be responsible for coordination of benefits to the extent that information regarding your other insurance is provided to the Plan by you,

the school or university which provided this Certificate, another insurance company, or any other entity or person authorized to provide such information.

Workers' compensation
When a Member is eligible for workers' compensation benefits through employment, the cost of vision treatment for an injury that arises out of and in the course of a Member's employment is not a Covered Benefit under this Plan. If the Plan pays for services that are covered by a workers' compensation policy, the Plan has the right to obtain reimbursement for those benefits paid. The Member must provide any assistance necessary, including furnishing information and signing necessary documents, for the Plan to receive the reimbursement.

Review of a benefit determination
If you are not satisfied with the Plan's benefit, please contact us at 1-844-252-0687(TTY:711). If, after speaking with our Health Care Concierge team, you are still dissatisfied, refer to the **Resolving Disputes with the Plan** subsection for further steps you can take regarding your claim.

Resolving Disputes with the Plan

At times, you may not be satisfied with a decision that UPMC Health Plan makes regarding coverage or with the health care services received. A dispute about the coverage, operations, or management policies of UPMC Health Plan or about a UPMC Health Plan Participant Provider is called a "Complaint." A dispute regarding UPMC Health Plan's denial, reduction, or termination of a benefit, or failure to make payment for a benefit – also known as an "Adverse Benefit Determination" – is called an "Appeal."

The Complaint process

If you have a dispute or objection regarding the coverage, operations, or management policies of UPMC Health Plan, or about a UPMC Health Plan Participating Provider, you may submit a Complaint to UPMC Health Plan. Complaints may be submitted about issues including, but not limited to, quality of care or services, benefits exclusions, or coordination of benefits. The Compliant process offers two levels of review.

At any time during the Complaint process, you may choose to designate a representative to act on your behalf. You must notify UPMC Health Plan in writing that you are designating someone to represent you and include a signed Personal Representative Designation (PRD) form signed by you and your designee. To obtain a PRD Form, visit www.upmchealthplan.com or call the Member Services number on your Member identification card.

You or your representative may file a Complaint with UPMC Health Plan in writing or over the phone. You can also file a complaint online by completing the online "Complaint or Appeal Submission Form" which can be found under "Plans and Coverage" on the UPMC Health Plan member site. To submit a Complaint in writing, please mail your complaint to PO Box 2939, Pittsburgh, PA 15230-2939. You are encouraged to send any other written information that you have to support your Complaint. Include in the Complaint the remedy, resolution, or corrective action that you want from UPMC Health Plan.

To submit a Complaint over the phone, you or your representative may call the Member Services phone number on your Member identification card. A Health Plan employee will assist you or your representative, at no charge, to prepare your Complaint, but will not be able to resolve your Complaint. This employee will not have previously participated in any of UPMC Health Plan's decisions regarding your Complaint.

First Level Complaint

You must submit your First Level Complaint within 180 days of the date on which the incident occurred. UPMC Health Plan will send you a letter to let you know we received the Complaint.

A First Level Complaint Review Committee will investigate the allegations in your Complaint within 30 days of receipt of your Compliant. The Committee will notify you of its decision in writing within five (5) business days of the decision. The notification letter will explain the Committee's decision and describe the process by which you may request a Second Level review of the decision.

Second Level Complaint

If you are not satisfied with the results of your First Level Complaint, you can request another review. You have 60 days from the date of the First Level Complaint Review Committee's decision letter to request another review. If you choose not to request a Second Level review within that time frame, the decision of the First Level Complaint Review Committee will be final.

If you submit a Second Level Complaint, UPMC Health Plan will send you a letter to let you know that we received your Complaint. We will also tell you the date and time for your Second Level Complaint Review Committee meeting. UPMC Health Plan will give you at least 15 calendar days' notice of the post-service review meeting and 7 calendar days' notice for the pre-service review meeting. We will also explain what happens at

review meetings and how you can participate in the meeting. You and/or your representative have the right, but are not required, to attend the Second Level Complaint Review Committee meeting. The meeting will be held at the offices of UPMC Health Plan.

If you or your representative cannot appear in person at the Second Level Complaint Review Committee meeting, UPMC Health Plan will provide you with the opportunity to participate in the review by telephone or other appropriate and available means. We will be as flexible as is reasonably possible in facilitating your participation.

The Second Level Complaint review will be completed within 45 days of receiving your request for such review. The Second Level Complaint Review Committee will issue a decision in writing to you and your representative within five (5) business days after the date of the meeting.

You are entitled to receive, upon request, reasonable access to and copies of all documents relevant to your Complaint free of charge. To request this documentation, please call the phone number on your member identification card.

The Adverse Benefit Determination Appeal process

You have the right to appeal any Adverse Benefit Determination made by UPMC Health Plan. An Adverse Benefit Determination includes the following:

1. A decision that a service is not covered because it is not Medically Necessary (including decisions about the appropriateness of service, health care setting, level of care, or effectiveness of a service);
2. A decision that a service is Experimental/Investigational;
3. An "Administrative Denial." An administrative denial is a decision to deny authorization, coverage, or payment for a service because (a) you are not eligible for coverage; (b) you or your provider failed to submit sufficient information with which to make a coverage decision; or (c) or your provider has failed to comply with an administrative policy of UPMC Health Plan.
4. A rescission of your coverage (cancellation of coverage based on a claim that you gave false or incomplete information when you applied for coverage).

You, your designated representative, or your provider who has your written consent may file an Appeal of an Adverse Benefit Determination. If you have given written consent to your Provider file an Appeal, please read the section below (Provider-Initiated Appeals) for more information.

You or your representative may file an Appeal with the UPMC Health Plan in writing or over the phone. You can also file an Appeal online by completing the online "Complaint or Appeal Submission Form" which can be found on the UPMC Health Plan member site. To submit an Appeal in writing, please mail your Appeal to P.O. Box 2939, Pittsburgh, PA 15230-2939. You are encouraged to send any other written information to support your Appeal. You may include in the Appeal the remedy, resolution, or corrective action you want from UPMC Health Plan.

To submit an Appeal over the phone, you or your representative may call the Member Services phone number on your Member identification card. A Health Plan employee will assist you or your representative, at no charge, to prepare your Appeal, but will not be able to resolve your Appeal. This employee will not have previously participated in any of UPMC Health Plan's decisions regarding your Appeal.

You are entitled to receive, upon request, reasonable access to either copies of all documents relevant to your Appeal free of charge, or instructions on how to obtain the documents. Documentation may include the benefit provision, guideline, protocol, diagnosis codes, or treatment codes on which the decision was based. To request this documentation, please call the phone number on your member identification card.

Provider-Initiated Appeals

You may give your provider consent to file an Appeal on your behalf. Please note that if you do so, you cannot file your own Appeal for the same denied treatment or service.

Here are some important rights regarding giving your provider consent to file an Appeal on your behalf:

- If you give your provider consent to file an Appeal on your behalf, that consent must be in writing, and it can be rescinded at any time.
- Your provider may not require you to give the provider permission to file an Appeal on your behalf as a condition of providing a treatment or service.
- Your provider must notify you if the provider decides not to file a Grievance.
- Your provider has 10 days to file an Appeal from the date of the denial of the treatment or services, and their ability to file a n Appeal on your behalf is automatically rescinded if they fail to do so.
- If your provider files the Appeal on your behalf, your provider may not bill you for the services that are the subject of the Appeal until the External Review process has been completed or you rescind your consent.

First Level Appeal

UPMC Health Plan's Adverse Benefit Determination appeal process offers two Levels of review. You must submit your First Level Appeal within 180 days of the date on which the denial occurred. For example, if your Appeal is regarding denial of pre-authorization for a service, you must file the Appeal within 180 days of the date on the letter you received informing you of that denial. While it is preferable that you file an Appeal in writing, you may call Member Services to request assistance and file an Appeal verbally. UPMC Health Plan will send you a letter to let you know your Appeal was received. UPMC Health Plan may also contact you to ask for additional information, if necessary to process your Appeal.

A First Level Adverse Benefit Determination Review Committee will investigate the allegations set forth in the Appeal. The Committee will seek input from a licensed health care provider with experience in the same or similar specialty that typically manages or consults regarding the disputed health care service If the Committee relies on or considers new or additional evidence in reviewing your Appeal or develops a new or additional rationale in denying your claim, it will provide that information to you free of charge. The Committee will also give you reasonable opportunity to respond before issuing a decision.

The Committee will notify you and your representative of its decision within 30 days of receipt of your Appeal (or 15 days for a pre-service coverage denial). The notification letter will explain the Committee's decision and describe the process to request a Second Level review of that decision. A copy of the decision letter will be sent to you and/or your representative and/or your provider, as applicable.

Second Level Appeal

If the Committee denies your First Level Appeal, you, your representative, or your provider has 60 days from the date on the First Level Adverse Benefit Determination Review to request another review. If you choose not to request a Second Level Appeal review within that time frame, the decision of the First Level Adverse Benefit Determination Review Committee will be final.

If you submit a Second Level Appeal, UPMC Health Plan will send you a letter to let you know we received your Appeal. We will also let you know the date and time for your Second Level Adverse Benefit Determination Review Committee meeting. UPMC Health Plan will give you at least 15 days' notice of the meeting. We will also explain what happens at review meetings and how you can participate in the meeting. You, your representative, or your provider has the right, but is not required, to attend the Second Level Adverse Benefit Determination Review Committee meeting. The meeting will be held at the offices of UPMC Health Plan. If you, your representative, and/or your provider cannot appear in person at the Second Level review, UPMC Health Plan will provide you, your representative, and your provider the opportunity to communicate with the review committee by telephone or

other appropriate and available means. We will be as flexible as is reasonably possible in facilitating your participation. If the Committee relies on or considers new or additional evidence in reviewing your Appeal or develops a new or additional rationale in denying your claim, it will provide that information to you free of charge. The Committee will also give you reasonable opportunity to respond before issuing a decision.

The Second Level Adverse Benefit Determination Review Committee will issue a written decision to you, your representative, or your provider, as applicable, within fifteen (15) calendar days of the request for a pre-service or thirty (30) calendar days for a post-service second level appeal. The decision letter will explain the decision and any further rights you may have available to you.

You are entitled to receive, upon request, reasonable access to either copies of all documents relevant to your Appeal or instructions on how to obtain the documents. Documentation may include the benefit provision, guideline, protocol, diagnosis codes, or treatment codes on which the decision was based. To request this documentation, please call the phone number on your member identification card.

The External Review process

If you and/or your provider are still dissatisfied with UPMC Health Plan's final decision regarding your Complaint or Adverse Benefit Determination, you may have the right to file a request for an external review by an Independent Review Organization (IRO). You, your representative, or your provider may file a request for an external review with UPMC Health Plan within four (4) months of the date on the Committee's decision letter. If your provider is filing the request for an external review, your provider must submit a copy of your written consent. The request must contain any materials, supporting information, or necessary justification for the external review.

An External Review may be requested for the following issues:

1. A decision that a service is not covered because it is not Medically Necessary (including decisions about the appropriateness of service, health care setting, level of care, or effectiveness of a service);
2. A decision that a service is Experimental/Investigational;
3. A rescission of your coverage (cancellation of coverage based on a claim that you gave false or incomplete information when you applied for coverage); and
4. Disputes regarding UPMC Health Plan's compliance with the surprise-billing and cost-sharing protections of the No Surprises Act.

Note that Administrative Denials are not eligible for external review by an IRO.

When the request for an external review is received, UPMC Health Plan will complete a preliminary review of the request within five (5) business days. The purpose of the preliminary review is to determine whether (1) you are a covered Member; (2) the service requested is a Covered Service under your plan (or would be a Covered Service if not Experimental/Investigational); (3) you exhausted internal appeals; and (4) you provided all information and forms necessary to process the external review.

Within one business (1) day after completion of the preliminary review, UPMC Health Plan will issue a notification to you in writing as to whether or not your request is eligible for an external review. We will tell you if we need additional information to determine eligibility for an external review. If we need additional information, we will tell you what we need and allow you to submit the additional information within the four (4) month filing period or within the 48-hour period following your receipt of notification, whichever is later. If your request is eligible for external review, we will notify you of the IRO name, address, and phone number.

Within five (5) business days of determining that your request is eligible for external review, UPMC Health Plan

will forward a copy of all written documentation regarding the adverse benefit determination to an IRO. Documentation will include the correspondence concerning the decision, all reasonable supporting documentation, and a summary of any applicable clinical rationale. At the same time, UPMC Health Plan will provide you, your representative, or your provider with the name and contact information of the assigned IRO, as well as a list of documents that are being forwarded to the IRO for the external review.

You, your representative, or your provider may supply additional information to the IRO to consider in the external review within five (5) business days after your receipt of this notice. The IRO will forward any additional information it receives to UPMC Health Plan to supplement our records.

The IRO will review all information UPMC Health Plan and you, your representative, or your provider provided. If applicable, the IRO will determine whether the service in question is/was Medically Necessary under the terms established by UPMC Health Plan. The IRO will issue a decision within 45 days of receipt of the external review. The decision will be issued in writing to UPMC Health Plan, you, your representative, or your physician. The decision notification will include the basis and clinical rationale for the decision, the credentials of the individual reviewer, and a list of information considered in the decision.

You are entitled to receive, upon request, reasonable access to and copies of all documents relevant to your Complaint or Appeal. Documentation includes the benefit provision, guideline, diagnosis codes, or treatment codes on which the decision was based. If you have any questions, please call the number on your member identification card.

Expedited review process
If you believe your life, health, or ability to regain maximum function may be jeopardized due to the standard time frames for standard internal Complaint or Adverse Benefit Determination review, you may request an expedited review from UPMC Health Plan at any stage of the Plan's review process.

Expedited internal review process
You may request an expedited internal review if your life, health, or ability to regain maximum function may be jeopardized due to the standard time frames for a standard internal review.

To request an expedited review, you should contact Member Services and explain the need for an expedited review. You must obtain written certification from your treating provider that your life, health, or ability to regain maximum function would be placed in jeopardy by the delay inherent in the regular time frames of the internal Complaint or Adverse Benefit Determination process. The certification must include a clinical rationale and facts to support your provider's position. UPMC Health Plan will inform you of the decision verbally and in writing.

The expedited review process follows all the requirements of a standard Second Level review — with the following exceptions:

- If UPMC Health Plan cannot accommodate you or the committee members as to time and distance to be present at the review, the review may be held by telephone or other appropriate and available means. UPMC Health Plan will ensure that all appropriate information is read into the record.
- You must provide any additional information for consideration in an expedited manner so UPMC Health Plan can comply with the requirements for an expedited review.
- The internal committee will issue a decision within 72 hours of receipt of the request for review and the provider certification described above.

Expedited external review process
You may request an expedited external review if your life, health, or ability to regain maximum function may be

jeopardized due to the standard time frames for a standard internal review.

To request an expedited external review, you should contact UPMC Health Plan and explain the need for an expedited external review. You must obtain written certification from your treating provider that your life, health, or ability to regain maximum function would be placed in jeopardy by the delay inherent in the regular time frames of the external review process. The certification must include a clinical rationale and facts to support your provider's position. You must provide any additional information for consideration in an expedited manner so we can comply with the requirements for an expedited review. Within 24 hours, UPMC Health Plan will submit your appeal to an IRO, which will provide you with notice of its decision as quickly as possible, but not later than 72 hours after our receipt of your request for the expedited external review.

ERISA appeal rights

You also may have appeal rights under section 502 (a) of the Employee Retirement Income Security Act (ERISA) if your benefit plan is an ERISA plan. You should contact your employer or plan sponsor to determine if your benefit plan is an ERISA plan and to ask what your appeal rights are under that plan. Remember that you must exhaust your administrative remedies prior to exercising your right to file a claim in a court of competent jurisdiction under ERISA. For questions about your rights or this notice or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Schedule of Exclusions

What is not covered

Not all vision services are Covered Services. The following is a list of services that are not covered under your vision plan. If you are not sure if a service is covered, call us at 1-844-252-0687 (TTY:711) to ask if that service is covered under your vision plan.

- **Blood**: Nonpurchase blood or blood products, including autologous donations.
- **Cosmetic surgery**: Surgical or other services performed solely for cosmetic reasons (to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons and from which no improvement in physiological function can be expected.)
- **Court-ordered services**: Court-ordered services when your vision provider or other professional provider determines that those services are not appropriate vision treatment.
- Employment-related or employer-sponsored services:
  A. For any illness or bodily injury that occurs in the course of employment, if benefits or compensation is available, in whole or in part, pursuant to any federal, state, or local government's workers' compensation, or occupational disease or similar type of legislation. This exclusion applies whether or not you claim those benefits or compensation.
  B. Services that you receive from a vision or medical department operated, in whole or in part, by or on behalf of, an employer, mutual benefit association, labor union, trust, or similar entity.

- **Experimental/Investigational**: Services that are Experimental/Investigational in nature as determined by the Plan.
- **Medical/Vision services not identified as "covered" in this Certificate:** Any other medical or vision service or treatment, except as provided in this Certificate or as mandated by law.
- **Medicare**: Services for which or to the extent that payment has been made pursuant to Medicare coverage, when Medicare coverage is primary.
- Military service:
  A. Care for military service-connected disabilities and conditions for which you are legally entitled to services and for which facilities are reasonably accessible to you.
  B. Services that are provided to Members of the armed forces and the National Health Service or to individuals in Veterans Administration facilities for military service-related illness or injury, unless you have a legal obligation to pay.
- **Miscellaneous**: Any services, supplies, or treatments not specifically listed in the Certificate as Covered Benefits, services, supplies, or treatments, unless they are a basic vision service.
  A. Any services related to or necessitated by an excluded item or noncovered service.
  B. Services provided by a unlicensed practitioner.
  C. Services that are primarily educational in nature.
  D. Services incurred after the date of termination of your coverage, except as provided elsewhere in this Certificate.
  E. Services rendered before the effective date of your coverage.
  F. Services for which you otherwise would have no legal obligation to pay.
  G. Charges for telephone consultations unless otherwise allowed in accordance with Plan Policy.
  H. Charges for failure to keep a scheduled appointment.
  I. Services performed by a vision provider enrolled in an education or training program when such services are related to the education or training program.
  J. Charges for completion of any insurance form or copying of vision or medical records.
  K. Services that are submitted by two different vision providers for the same services performed on the same date for the same individual.
  L. Services for, or related to, any illness or injury suffered after the effective date of your coverage that is the result of any act of war.

M. Services that are more than the Usual, Customary, and Reasonable charge.
N. Charges for vision care that is not deemed necessary to improve visual impairment.
O. Expenses incurred by you to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. The Plan will take into account any adjustment option chosen under such part by you.
P. Vision examination or materials required for employment.
Q. Replacement of lost or stolen eyewear (glasses or contact lenses) or broken or damaged lenses, unless otherwise stated in plan documents. NVA network providers may offer additional warranties to cover materials unless otherwise stated in plan documents.
R. Contact lenses or frames except at normal intervals when service would otherwise be available.
S. Services or materials provided by federal, state, local government or workers' compensation.
T. Industrial safety lenses and safety frames with or without side shields.
U. Parts or repair of frame/sunglasses.
V. Replacement of a lost or stolen appliance

- **Motor vehicle accident/workers' compensation**: Treatment or services for injuries resulting from the maintenance or use of a motor vehicle to the extent that such treatment or service is paid or payable under a motor vehicle insurance policy, or any injury suffered in the course and scope of performing work for which coverage is afforded under a workers' compensation policy, including, but not limited to, a qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical or vision benefits established by law, including medical benefits payment in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act or an equivalent law of another state.
- **Prescription drugs**.
- **Professional services and/or materials in connection with**:
    - Plano (nonprescription) lenses.
    - Aniseikonic lenses.
    - Subnormal visual aids.
    - Orthoptics, vision training, developmental vision procedures, and any associated supplemental testing.
    - Two pairs of glasses in lieu of bifocals.

General Provisions

This Certificate includes and incorporates any and all Schedules of Benefits and, together, the Pediatric Vision Certificate of Insurance and Pediatric Vision Schedule of Benefits represent the entire agreement between the parties with respect to the subject matter. The failure of any section or subsection of this Certificate shall not affect the validity, legality, and enforceability of the remaining sections.

Except as otherwise herein provided, this Certificate may be amended, changed, or modified only in writing by the Plan and thereafter attached hereto as part of this Certificate.

The Plan may assign this Certificate and its rights and obligations hereunder to any entity under common control with the Plan.

Amendment
Anything contained herein to the contrary notwithstanding, UPMC Health Plan shall have the right, for the purpose of complying with the provisions of any law or any lawful order of a regulatory authority, to amend the Certificate or any attachment hereto or to increase, reduce, or eliminate any of the benefits provided for in the Certificate for any one or more eligible Members enrolled under the Certificate, and each party hereby agrees to any amendment of the Certificate which is necessary in order to accomplish such purpose.

Application and statements
Applicants for coverage under this plan shall complete and submit such application or other forms or statements as UPMC Health Plan may reasonably request. Applicants for coverage under this plan represent that all information contained in such application forms, or statements submitted for enrollment under this Certificate or the administration hereof shall be true, correct, and complete to the best of their knowledge or belief, and all rights to benefits hereunder are subject to the condition that such information shall be true, correct, and complete. A person who knowingly and with intent to defraud UPMC Health Plan by completing forms containing false information or by omitting relevant information commits a fraudulent insurance act, which is a crime and may be subject to criminal and civil penalties or the termination of coverage hereunder. Please see the Time limit on certain defenses (below) provision regarding information you submitted.

Entire contract; changes
Subject to the contract between your school or university and UPMC Health Plan, this Certificate of Insurance, including the schedules, riders and other documents attached hereto and issued in accordance herewith, represents the entire contract of insurance between your school or university and UPMC Health Plan. No change in this Certificate shall be valid until approved by a Health Plan officer and unless such approval be endorsed hereon or attached hereto.

Fraud, waste and abuse
According to Pennsylvania statute:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

UPMC Health Plan is committed to the integrity of, provision of, and payment for health care services to our Members. In the event that you suspect that a UPMC Health Plan Member or provider is committing fraud or abuse, contact our Special Investigations Unit at 1-866-FRAUD01 (1-866-372-8301) or specialinvestigationsunit@upmc.edu.

Governing Law
This Certificate is entered into and is subject to the laws of the Commonwealth of Pennsylvania. The invalidity or

unenforceability of any terms or conditions hereof in no way affects the validity or enforceability of any other terms or provision. The waiver by either party of a breach or violation of any provision of this Certificate shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

Legal actions

No action in law or in equity shall be brought to recover on the policy prior to the expiration of sixty (60) days after written Proof of Loss has been filed in accordance with the requirements of the policy. No such action shall be brought after the expiration of three (3) years after the time written Proof of Loss for Covered Services is required to be furnished.

Misstatement of age

If your age has been misstated, all amounts payable under the plan shall be the premium amount owed if the plan had been purchased at the correct age.

Physical examinations

The Plan, at its own expense, shall have the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a claim hereunder.

Grace period

Subject to meeting the eligibility requirements as determined by your school or university which provided this Certificate, a grace period of thirty (30) days from the due date will be granted for payment of the required premium. During the grace period, the Certificate will remain in force. If the required premium payment is not received by the end of the thirty (30)-day grace period, the Certificate will automatically terminate effective the end of the Grace Period. Any claims received and found otherwise eligible during the Grace Period will be paid and may be reduced by any then outstanding premiums.

Reinstatement

If your coverage under this Certificate has been terminated for failure to pay premiums, the Plan will reinstate your coverage as long as the premium due is paid in full within 30-calendar days after the end of the grace period and you meet the eligibility requirements as determined by your school or university which is provided in this Certificate. In all other respects the insured and insurer shall have the same rights thereunder as they had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

Release of information

Each Member agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under the Certificate may furnish to UPMC Health Plan, upon its request, any information (including copies of records) relating to the illness or injury. In addition, UPMC Health Plan may furnish similar information regarding claims and charges that providers submitted to UPMC Health Plan to other entities that provide similar benefits at the entity's request. Each Member further agrees that approval by UPMC Health Plan of any benefits for services rendered under the Certificate is contingent upon furnishing such information or records or copies of records.

Time Limit on Certain Defenses

No misstatements, except fraudulent misstatements, made by the applicant in the application for such coverage shall be used to void this plan or to deny a claim commencing after the expiration of three years from the date of issue of this Certificate. All statements you made will, in the absence of fraud, be deemed representation, and not warranties and no such statement will be in defense to a claim under this Certificate, unless it is contained in a written instrument signed by and furnished to you. UPMC Health Plan will not reduce or deny any claim for loss that you may incur from the date your plan started on the grounds that a disease or physical condition existed before the date your plan started, unless the disease or physical condition was excluded from coverage by name or by a specific description that was in effect on the date of loss. Material misrepresentations will, at the option of UPMC Health Plan, render this plan void from inception, provided that such

material misrepresentations are discovered by UPMC Health Plan within three (3) years of the Effective Date. In the event UPMC Health Plan elects to void this Plan, you forfeit any charges paid to the extent of any liability incurred by UPMC Health Plan.

Nondiscrimination Notice

UPMC Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. **UPMC Health Plan** does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

UPMC Health Plan:

Provides people with disabilities reasonable modifications and free and timely appropriate auxiliary aids and services to communicate effectively with us, such as:

− Qualified interpreters
− Written information in other formats (large print, Braille, other formats).

Provides free and timely language assistance services to people whose primary language is not English, which may include:

− Qualified interpreters
− Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact **UPMC Health Plan Member Services at** 1-844-220-4785. Help is available Monday to Friday 8 a.m. to 6 p.m.

If you believe that **UPMC Health Plan** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a complaint/ grievance with:

Complaints/Grievances/Appeals
Attn: Chief Risk, Compliance & Ethics Officer PO Box 2939
Pittsburgh, PA 15230-2939
Phone: 1-844-220-4785
TTY: 711
Fax: 412-454-7920
Email: HealthPlanCompliance@upmc.edu

You can file a complaint/grievance in person or by mail, fax, or email. If you need help filing a complaint/ grievance, **UPMC Health Plan Member Services** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

This notice is available at **UPMC Health Plan's** website: **https://www.upmchealthplan.com/members/**

UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products, or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC *for You* Inc., Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

Translation Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-489-3494 (TTY:711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-489-3494 （TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-489-3494 (TTY:711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-489-3494 (телетайп:711).

Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-489-3494 (TTY:711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-489-3494 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-489-3494 (TTY:711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-489-3494 (رقم هاتف الصم والبكم: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-489-3494 (ATS :711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-489-3494 (TTY:711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-489-3494 (TTY:711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-489-3494 (TTY:711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-489-3494 (TTY:711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-489-3494 (TTY:711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-489-3494 (TTY:711).