Welcome to Vision Benefits of America (VBA). We pride ourselves on keeping things simple for you. We know that benefits can be difficult to figure out. We are here to help you understand your benefit coverages and learn more about the products and services available to you through your plan.

We are including the following materials that contain key information regarding your enhanced vision program:

## Beneficial Resources

**Insurance Certificate** - This certificate describes your group's vision care coverage and includes the Schedule of Benefits. A digital or print copy should be shared with all enrolled employees.

**Benefit Summary** - This benefit summary describes your group's vision care coverage. A digital or print copy should be shared with all enrolled employees.

**Member ID Card** -- While ID cards are not needed to use in-network benefits, this flier explains how to utilize this vision care program and any additional offerings through TLC, Qualsight and Hear USA. This flier also includes an informational ID wallet card, which can be cut out and carried.

Employees who want a customized ID card should visit the VBA Member Portal at https://members.vbaplans.com/.

**Network Access** – This sheet describes VBA's participating provider network, how to access in-network benefits and how to submit an out-of-network claim.

**Using the VBA Member Portal** – This sheet provides a brief overview of the VBA Member Portal.

**Protect Your Privacy** - This sheet describes VBA's Notice of Privacy Practices. You may find this useful on a bulletin board or employee message center.

**PA LHIGA** – Notice Required by Pennsylvania.

## Resources on VBA's Website

Visit our website www.vbaplans.com for more resources like Answers to Frequently Asked Questions and VBA's Provider Finder.

## Contact Us

**Member Services** - Our Member Services Department is available by chat on our Member Portal, email at memberservices@vbaplans.com or by calling 1-800-432-4966 option 1, Monday through Friday, 8:30 A.M. to 6:00 P.M. ET.

# VISION BENEFITS OF AMERICA, INC.

400 Lydia Street, Suite 300
Carnegie, PA 15106
800-432-4966

## CERTIFICATE OF INSURANCE FOR GROUP VISION INSURANCE

**About Your Insurance** – This Certificate explains the vision insurance coverage under the Policy issued to the Policyholder, which is underwritten by Vision Benefits of America, Inc. (hereinafter called: We, Our, Us, the Company, or VBA). The Policy provides benefits for the Insured Persons (hereinafter called: You or Your). Read it closely to become familiar with Your plan.

Coverage is effective as of the Certificate Effective Date shown on the Schedule of Benefits. Terms important to understanding this Certificate are defined in the Definitions section or in separate Certificate provisions sections and are capitalized in this Certificate.

**Renewal Conditions**
After the initial term, this Certificate shall continue on a 24 months basis. It will automatically renew on each Policy Anniversary unless terminated in accordance with the Termination of Insurance provision or either We or the Policyholder has given to the other at least 45 days advance written notice.

The Policy under which this Certificate is issued may at any time be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice by Us to any Insured Person who claims rights or benefits under the Policy. The Policyholder is responsible for providing notice, if any, to the Insured Persons.

The Policy provides the benefits described in this Certificate for Insured Persons. This Certificate with any attached Riders, Endorsements, or Amendments, as well as the Application and Enrollment Form, make up the Certificate of Insurance. It replaces any prior Certificates of Insurance issued under the Policy.

**Notice of Insured's Right to Examine Certificate for Ten Days**
The Company urges the Insured to examine this Certificate closely. If the Insured is not satisfied with it, the Insured may be able to send it back to the Company at 400 Lydia Street, Suite 300 Carnegie, PA 15106 or its Administrator for any reason within 10 days after the date the Insured receives it. If returned, the Insured's insurance will be void from the beginning. This means that you will be responsible for payment in full of any services received or materials purchased from the Effective Date to the date the Certificate is voided. Any premium paid will be refunded in full less any claims that have already been paid by the Company.

In witness whereof, the Vision Benefits of America, Inc. president and treasurer signed this Certificate, as of the Insured Member's effective date of coverage.

**NON-PARTICIPATING**
**THIS IS A LIMITED CERTIFICATE – READ IT CAREFULLY**

Jeff A. Hollowood
President

Aaron R. Risden
Treasurer

## NOTICE

Vision Benefits of America, Inc. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Coverage for medically necessary health services is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. Vision Benefits of America, Inc. will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. Vision Benefits of America, Inc. will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

## SECTION 1 – TABLE OF CONTENTS

## Contents

# VISION BENEFITS OF AMERICA, INC.

## SECTION 2 – SCHEDULE OF BENEFITS

| | | | |
|---|---|---|---|
| **Policyholder:** | Govberg, LLC dba The 1916 Company | **Policy Anniversary:** | September 1 |
| **Policyholder's Address:** | 166 E. Levering Mill Road<br>Bala Cynwyd, PA 19004 | **Initial Term:** | 24 Months |
| **Policy Number:** | 4693 | **Place of Delivery** | Pennsylvania |
| **Policy Effective Date:** | September 1, 2026 | | |
| **Eligible Classes:** | All Actively at Work Eligible Members and Eligible Dependents completing the Eligibility Period | | |
| **Eligibility Period:** | Coverage begins the first day of the month following the date of hire. | | |
| **Mode of Premium Payment:** | Monthly | | |
| **Method of Premium Payment:** | Remitted by Policyholder to Us | | |
| **Premium Due Date:** | 1st of each month | | |
| **Premium Amount:** | | | |

| Employee Only | Employee + Spouse | Employee + Child (ren) | Employee + Family |
|---|---|---|---|
| $ 3.98 | $ 9.38 | $ 9.65 | $ 13.54 |

**Plan Year:** Policy Year

| | In-Network | Out-of-Network* | Benefit Frequency |
|---|---|---|---|
| **SERVICES** | | | |
| Vision Exam | Covered in full after $10 Copay | Reimbursement up to $100 | Once Every 12 months from last date of service |
| Contact Lens Fit | 15% Discount | No reimbursement available | |
| Retinal Screening | Not Covered | Not Covered | Once Every 12 months from last date of service |

| MATERIALS | | | |
|---|---|---|---|
| Materials Copay<br>*Applies to Standard Lenses and Frames* | $25 Copay | | *See below* |
| Eyeglass Lenses<br>(CR-39 standard plastic or glass)<br><br>*In lieu of Elective Contact Lenses or Medically Necessary Contact Lenses* | Standard Lenses:<br>Single<br>Bifocal<br>Trifocal<br>Lenticular<br>Covered in full after $25 Copay | Standard Lenses reimbursement up to:<br>Single $60<br>Bifocal $80<br>Trifocal $100<br>Progressive $100<br>Lenticular $140 | Once Every 12 months from last date of service |
| Eyeglass Frames<br><br>*In lieu of Elective Contact Lenses or Medically Necessary Contact Lenses* | $50 wholesale allowance less applicable Copay | Reimbursement up to $100 | Once Every 12 months from last date of service |
| Contact Lenses<br>Elective<br><br>*In lieu of Eyeglass Frames and Lenses or Medically Necessary Contact Lenses* | $110 allowance | Reimbursement up to $110 | Once Every 12 months from last date of service |
| Contact Lenses<br>Medically Necessary<br><br>*In lieu of Eyeglass Frames and Lenses or Elective Contact Lenses* | Covered in full subject to prior authorization | Reimbursement up to $450 | Once Every 12 months from last date of service |
| Coverage A<br><br>Options:<br>Basic Scratch Coating<br>Standard Polycarbonate Lenses for Covered Persons up to age 19<br><br>*When purchased with standard lenses* | Covered in full after $25 Copay | In-network benefit only | Once Every 12 months from last date of service |

| | | | |
|---|---|---|---|
| *In lieu of Elective Contact lenses or Medically Necessary Contact Lenses* | | | |
| Coverage B<br>Options:<br>Basic Progressive Lenses<br>Standard Progressive Lenses<br>Premium 1 Progressive Lenses<br>Premium 2 Progressive Lenses<br>Premium 3 Progressive Lenses<br>Premium 4 Progressive Lenses<br>Near Variable Focus<br>Standard A/R 1<br>Standard A/R 2<br>Premium A/R 1<br>Premium A/R 2<br>Ultra A/R<br>Blue Protection Material<br>Polycarbonate (19 & Over)<br>Digital Surfacing, Single Vision<br>Polarized<br>Color Coating<br>Rimless Mounting<br>UV 400<br>Mid-Index/Trivex<br>High Index<br>Photochromic<br>Mirror Coating<br>Edge Treatments<br>Premium Scratch<br>Solid or Gradient Tint<br><br>*When purchased with standard lenses*<br><br>*In lieu of Elective Contact lenses or Medically Necessary Contact Lenses* | Discount Pricing | No reimbursement available | Once Every 12 months from last date of service |

| | | | |
|---|---|---|---|
| Low Vision Aids | Out-of-Network benefit only | Reimbursement up to $650 | Once Every 24 months from last date of service – no lifetime maximum |
| Laser Vision Correction (LASIK) | Out-of-Network benefit only | Reimbursement up to $125 | Once Every 8 years from last date of service -no lifetime maximum |

Where an “allowance” is shown above, You are responsible for paying any charges in excess of the allowance less any applicable Copay.

Where “Discount Pricing” is shown above, You are responsible for paying for such items, and there may be discount pricing available when received from certain In-Network Providers unless otherwise prohibited by law. You may contact VBA at 1-800-432-4966 for more information regarding the discounted pricing available from In-Network Providers.

Benefits may vary at participating retail locations including Costco® Optical, LensCrafters®, Pearle Vision®, Target Optical® and Visionworks®. You may contact VBA at 1-800-432-4966 for more information regarding their benefits at retail locations.

* Submit Out-of-Network Reimbursement Form and an itemized paid receipt to Vision Benefits of America, Inc.

** If a member is unable to attain access to an in-network-provider the Company will cover out-of-network benefits as in-network benefits.

## SECTION 3 – DEFINITIONS

**Actively at Work:** the performance of the normal duties of Your usual job on a Full-Time basis at Your usual place of work or at another place to which You are required to travel. You must be able to perform all the duties of Your regular occupation. You will be considered to be Actively at Work while on a paid vacation day or regular non-working day.

**Calendar Year:** the period beginning on the Policy Effective Date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

**Copay:** an Insured Person's share of the costs for Covered Services or Materials that are provided by an In-Network Provider. The Copay is paid directly to the Provider at the time services are rendered. Copay amounts are listed in the Schedule of Benefits.

**Covered Services or Materials:** the Vision Exam services and Materials that qualify for benefits under the Policy. Covered Services or Materials are shown in the Schedule of Benefits.

**Elective Contact Lenses:** contact lenses an Insured Person elects to wear instead of eyeglasses for reasons of comfort or appearance.

**Eligibility Period:** the period of time that an Eligible Member must wait before They are eligible for coverage. This period, if any, is specified in the Policyholder's Application and shown on the Schedule of Benefits.

**Eligible Class:** a group of people who are eligible for coverage under the Policy. See the Schedule of Benefits for a list of Eligible Classes. Each person of the Eligible Class will qualify to enroll for insurance on the date They complete the required Eligibility Period.

**Eligible Dependent:** someone who is residing in the United States and who is:

1. Your legally married spouse or lawful domestic partner; or
2. Your or Your spouse's natural child, stepchild, legally adopted child from the date of placement, child in Your custodial care pursuant to a court order, or child for whom You have been appointed as legal guardian, who is under age 26.

Coverage will continue for any Eligible Dependent child, regardless of age, who is incapable of self-sustaining employment by reason of intellectual or physical disability, and who became so disabled prior to age 26 and while covered under this Certificate. You must furnish proof of such disability and dependency to Us within 31 days of the Eligible Dependent child's 26th birthday. You must furnish proof of continuing disability and dependency at Our request, but not more often than annually, after the two-year period following the Eligible Dependent child's 26th birthday.

**Eligible Member:** a person who belongs to an Eligible Class.

**Eyeglass Lenses:** a standard glass or plastic (CR39) lens, which is optically clear, that will fit an eye glass frame with a lens size less than 61mm in length. Standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, through flat top 28 for glass trifocals, blended bifocals, and through flat top 35 for plastic trifocals.

**Family Members:** a unit consisting of You and each of Your Insured Dependents.

**Full-Time:** a regular workweek as shown in the description of Eligible Classes in the Schedule of Benefits.

**Group:** the employer, union, trust, association, or other eligible entity or organization to which the Policy is issued.

**In-Network Provider:** an Ophthalmologist, Optometrist or Optician who has entered into an agreement with Us to provide Covered Services or Materials at an agreed-to cost. When an In-Network Provider is used, the Insured Person will generally incur less out-of-pocket cost for the services rendered.

**Initial Term:** the period following the Group's initial Effective Date and shown in the Schedule of Benefits. Rates are guaranteed not to change during this period.

**Insured Dependent:** an Eligible Dependent of an Insured Member for whom insurance under the Policy has become effective.

**Insured Member:** a person who is an Eligible Member of an Eligible Class, who has qualified for insurance by completing the Eligibility Period, and for whom insurance under the Policy has become effective.

**Insured Person:** an Insured Member and Insured Dependents.

**Late Entrant:** any Eligible Member or Eligible Dependent enrolling outside the Policyholder's initial Eligibility Period as indicated in the Schedule of Benefits.

**Materials:** corrective Eyeglass Lenses, Frames, and Contact Lenses.

**Medically Necessary Contact Lenses** means contact lenses for an Insured Person who:

1. has undergone cataract surgery without Intraocular Lens(es),
2. has a prescription greater +/- 12.00 Diopters in both eyes for adults and above +/- 10.00 Diopters in both eyes for children.
3. has Keratoconus,
4. has Penetrating Keratoplasty (corneal transplant),
5. has anisometropia of 4.00D or more,
6. has retinal detachment only if peripheral vision problems are present,
7. has Aphakia (acquired cataract, but not "pseudo-aphakia),
8. has vision that can be corrected to 20/70 when compared to current, standard spectacle lenses.

**Ophthalmologist:** a person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology. The Ophthalmologist cannot be 1) the Insured Person; 2) a Family Member; or 3) retained by the Policyholder.

**Optician:** a person or business that grinds and/or dispenses Eyeglass Lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician cannot be: 1) the Insured Person; 2) a Family Member; or 3) retained by the Policyholder. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.

**Optometrist:** a person licensed to practice optometry as defined by the laws of the state in which services are rendered. The Optometrist cannot be 1) the Insured Person; 2) a Family Member; or 3) retained by the Policyholder.

**Out-of-Network Provider:** an Ophthalmologist, Optometrist or Optician who is not an In-Network Provider. These providers have not entered into an agreement with Us to limit their charges.

**Plano Lens:** a lens that has no refractive power.

**Policy:** the entire contract. It consists of:

1. the Policy;
2. the Policyholder's Application;
3. any Riders, Endorsements and Amendments;
4. the Certificate of Insurance; and
5. the Enrollment Form, if any.

**Premium:** the amount of money paid on a recurring basis to purchase the insurance benefits provided by the Policy.

**Policy Anniversary:** the month and day as shown on the Policy as the Policy Anniversary.

**Policy Year:** for the first year, the period of time that begins on the Effective Date and ends on the day before the next following Policy Anniversary. For subsequent years, it is the period of time that begins on the first and each subsequent Policy Anniversary and ends on the day before the next Policy Anniversary.

**Policyholder:** the Group listed in the Schedule of Benefits to which the Group Master Policy has been issued.

**Re-enrollee:** any Insured who terminated Their coverage, and then subsequently re-enrolled for coverage at a later date. Benefits may be limited for Re-enrollees.

**Their, Them, They** refers to male, female, or nonbinary individuals.

**Vision Care Exam:** an examination of principal vision functions. A Vision Care Exam includes, but is not limited to, case history, external and internal examination of the eyes, refraction and visual acuity, muscle balance and fusion evaluation, near point tests, depth and color perception tests and tonometry, if indicated. The exam must be consistent with the community standards, rules and regulations of the jurisdiction in which the provider's practice is located.

**We, Us, Our, the Company, VBA:** Vision Benefits of America, Inc.

**You, Your:** an Insured Member.

## SECTION 4 – ELIGIBILITY

To be eligible for coverage under the Policy, an individual must:

1. be a person of an Eligible Class of the Policyholder, as defined in the Schedule of Benefits; and
2. satisfy the Eligibility Period, if any.

The Eligible Member's Eligible Dependents are also eligible for coverage, provided that the Eligible Member becomes insured under the Policy and Dependent coverage is provided under the Policy.

Dual Eligibility Status: If both an Eligible Member and Their spouse or lawful domestic partner are in an Eligible Class of the Policyholder, enrollment will default to the Policyholder's rules.

## SECTION 5 – ENROLLMENT

The term "Enrollment" means written or electronic enrollment in the coverage by an Eligible Member on an Enrollment Form furnished or approved by Us. Coverage will not become effective until the Eligible Members have enrolled themselves and, if applicable, their Eligible Dependents, and paid the required Premium, if any.

Permitted Change in Election Event: Members may enroll in or change their coverage outside of a designated Enrollment period if a permitted change in election event occurs, provided the Insured Member makes written application to enroll within 31 days of the event. A permitted change in election event means any of the following:

1. marriage or lawful domestic partnership,
2. divorce or legal separation,
3. birth or adoption of a child,
4. placement of a child in Your custodial care pursuant to a court order,
5. You being appointed legal guardian of a child,
6. death of a spouse or lawful domestic partner or child, or
7. other changes as permitted by Us and the Policyholder.

## SECTION 6 – EFFECTIVE DATE

**Eligible Members and Eligible Dependents**
Coverage takes effect on the Certificate Effective Date shown in the Schedule of Benefits.

**Additional Dependents**
The Effective Date of any newly acquired Eligible Dependent will be governed by the same rules as described above under the heading "Eligible Members and Eligible Dependents." You must first complete, sign and submit to Us a new Enrollment Form or electronic enrollment for all Your Additional Dependents, including newborn children, and submit the additional Premium, if any. However, newborn children will be covered for the first 90 days following their birth. To continue coverage beyond that 90-day period, You must notify Us of the child's date of birth at any time during the 90-day period.

## SECTION 7 – TERMINATION

**Insured Members**
All of Your insurance under the Policy will terminate at 11:59 p.m. at the main office of the Policyholder on the earliest of the following dates:

1. the date the Policy terminates;
2. the last day of the month in which You cease to be an Eligible Member;
3. the date You die; or
4. on any Premium Due Date, when full payment for insurance is not made within the Grace Period.

If an event that is described above occurs, written notice must be provided to Us, by You or the Policyholder, within 31 days of such event.

**Insured Dependents**
Your Dependent's insurance under the Policy will terminate at 11:59 p.m. at the main office of the Policyholder on the earliest of the following dates:

1. the date the Policy terminates;
2. the last day of the month in which You cease to be an Eligible Member;
3. the date the Insured Dependent ceases to be an Eligible Dependent;
4. the date You die;
5. the date the Insured Dependent dies;
6. on any Premium Due Date, when full payment for insurance is not made within the Grace Period; or
7. the date We receive Your request to terminate Dependent coverage subject to any limitation imposed by the Policyholder.

If an event that is described above occurs, written notice must be provided to Us, by You or the Policyholder, within 31 days of such event.

**Notice Required When Your Coverage Terminates**
We must be informed promptly, by You or the Policyholder, when Your status as an Eligible Member terminates for any reason. Failure to provide timely notice will not continue Your insurance past the time it would have otherwise ended as provided above.

In the event Premiums have been paid to Us on Your behalf after Your coverage should have terminated, We will refund the Premium for the period for which Premiums were paid in error up to a maximum of three Policy months or to the last Policy Anniversary, whichever is less. If We are not notified that Your coverage is terminated and We pay any benefits for Your Covered Services or Materials incurred after the date Your coverage terminated, the full amount of those benefits will be considered an overpayment which must be repaid to Us.

**Our Right To Terminate Policy**

We have the right to terminate coverage under the Policy on any Premium Due Date after the Initial Term of the Policy as follows:

1. nonpayment of premium,
2. fraud,
3. violation of participation and/or contribution rules,
4. We decide to discontinue coverage of this type in the insurance market with at least 90 days' written notice to the Policyholder in accordance to state and federal law;
5. movement outside the service area.

Insurance will end as provided above without the consent of, or notice by Us, to any Insured Person. Notice will be sent to the Policyholder at the last address shown in Our records. It is the Policyholder's responsibility to notify the Insured Persons.

**COBRA Continuation of Benefits**

**Applicability**

Federal Law requires that employers of 20 or more employees offer temporary extension of health coverage to Qualified Beneficiaries of employees employed at least 50% of the preceding year when coverage would otherwise end because one or more of the Qualifying Events listed below occurs. Under COBRA, the term Qualified Beneficiary means any individual who, on the day before a Qualifying Event, is covered under the Policy and is not:

1. already covered under the Policy by reason of another individual's election of COBRA Continuation Benefits; or
2. entitled to Medicare benefits under Title XVIII of the Social Security Act.

**Qualifying Events**

For purposes of coverage under COBRA, any of the events in the following table would result in the loss of coverage for a Qualified Beneficiary and would require an employer subject to COBRA to offer a temporary extension of health coverage up to the Continuation Coverage Period shown.

| Qualifying Event | Continuation Coverage Period |
|---|---|
| • Death of an Insured Member | 36 months |
| • Termination of employment for any reason or the reduction in hours that would result in loss of coverage | 18 months* |
| • Divorce or legal separation | 36 months |
| • The Insured Member becomes eligible for Medicare | Insured Dependents allowed 36 months |
| • An Insured Member's Insured Dependent no longer meets the eligibility requirements | 36 months |

* Coverage may be continued for an additional 11 months, for a total of 29 months, if the Qualified Beneficiary:
  1. is determined disabled for Social Security purposes at the time of the Qualifying Event or within 60 days after continuation coverage begins; and
  2 notifies the plan administrator within 60 days from determination but before the 18-month continuation period ends.

Qualified Beneficiaries may be covered by more than one Qualifying Event. However, in no event may the total coverage continuation period exceed 36 months from all Qualifying Events.

**Notice and Election**
Insured Members are responsible for notifying their employer within 31 days of the occurrence of a Qualifying Event. The employer must notify the plan administrator of the Qualifying Event. The employer must also notify the Qualified Beneficiaries of their COBRA election rights. The period during which the Qualified Beneficiary must elect or decline continuation of coverage under COBRA ends not earlier than 60 days after the later of:

1. the date that coverage would end under the Policy by reason of a Qualifying Event; or
2. the date the Qualified Beneficiary receives notice of their COBRA election rights from the plan administrator.

**Premium Payment**
The Qualified Beneficiary must pay to the employer the required weekly, biweekly, monthly, quarterly, semi-annual, annual premium for continued coverage. Any Grace Period applying to the employer will also apply to the Qualified Beneficiary, except for the first premium payment. Payment of premium for coverage under the period preceding the election must be made within 45 days of the date of the election.

**Termination of Continued Benefits**
Benefits continued under COBRA will end on the first date that one of the following events occurs:

1. The premium for continued coverage is not paid within 31 days from when it is due;
2. The Qualified Beneficiary becomes covered under another group health plan providing the same or similar benefits, if that plan does not contain any exclusion or limitation on any pre-existing conditions of the Qualified Beneficiary;
3. The Qualified Beneficiary becomes eligible for Medicare;
4. The Qualified Beneficiary, who is divorced from an insured employee, remarries and is covered under the new spouse's health plan;
5. The Coverage Continuation Period applicable to a Qualified Beneficiary ends; or
6. The employer terminates coverage provided by the Policy.

## SECTION 8 – PREMIUM PROVISIONS

**Payment of Premiums**
Insured Persons may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. If required, You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us.

**Grace Period**
A Grace Period of 31 days following the Premium Due Date is granted for the payment of each Premium Due Date after the first. The coverage stays in force if the Premium is paid during this Grace Period, unless We are given written notice that the insurance is to be ended before the Grace Period. Any claim received or incurred during the Grace Period may be reduced by the amount of premium due.

**Right to Change Premiums**
We have the right to change the Premium rates on any Premium Due Date after the Initial Term. After the Policy Anniversary Date, We will not increase the Premium rates more than once in a 12 month period. We will give the Policyholder written notice at least 60 days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

## SECTION 9 – CLAIM PROVISIONS

**Notice of Claim**
Written Notice of Claim must be provided within 90 days from the date of loss or as soon as reasonably possible. We will not deny or reduce any claim filed after 90 days from the date of loss if it was not reasonably possible to file the claim within that 90-day period, and the claim is filed as soon as it is reasonably possible. Notice must be given to the Company at 400 Lydia Street, Suite 300, Carnegie, PA 15106. We will not deny or reduce any claim filed after 90 days from the date of loss if it was not reasonably possible to file the claim within that 90-day period, and the claim is filed as soon as it is reasonably possible.

**Proof of Loss**
Written Proof of Loss (claim forms, medical bills, medical authorizations, or other reasonable evidence of the claim that is ordinarily required) must be furnished to Us within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

**Claim Forms**
When We receive Notice of Claim, forms for filing Proof of Loss will be sent to the claimant. If these forms are not provided within 15 days after the giving of such notice, the claimant will meet the Proof of Loss requirements if We are given written proof of the occurrence, character, and extent of the loss for which claim is made.

**Payment of Claims**
All Out-of-Network Benefits will be payable to You. All In-Network Benefits will be payable directly to the In-Network Provider. Any accrued benefits unpaid at Your death will be paid to Your estate. Any payment made by Us in good faith pursuant to this provision will fully release Us to the extent of such payment.

**Time of Payment of Claims**
All benefits under the Policy will be paid immediately upon receipt of due written proof of loss. However, no benefits will be paid until the required written Proof of Loss has been submitted to Us.

**Recovery of Overpayments**
We reserve the right to recover an overpayment from any Insured Person or entity to whom actual payment was made under the Policy:

1. in error; or
2. pursuant to a misstatement contained in a Proof of Loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under the Policy within two years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such recovery will only be to the extent permitted by law.

## SECTION 10 – COORDINATION OF BENEFITS (COB)

This provision applies when an Insured Person has vision coverage under more than one Plan, as defined below. The benefits payable between the Plans will be coordinated.

**Definitions Related to COB**

1. **Allowable Expense:** An expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by Services, reasonable cash value of each Service will be treated as both an Allowable Expense and a benefit paid.
2. **Coordination of Benefits (COB):** Taking other Plans into account when We pay benefits.
3. **Plan:** Any plan, including this one that provides benefits or Services for vision expenses on either a group or individual basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no-fault insurance (when allowed by law). "Plan" shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or Services of other plans and that part which does not.
4. **Primary Plan:** The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.
5. **Year:** The Calendar Year, or any part of it, during which a person claiming benefits is covered under this Plan.

**Benefit Coordination**

Benefits will be adjusted so the total payment under all Plans is no more than 100 percent of the Insured Person's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of COB.

If an Insured Person's benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable Plan Year Benefit Maximum.

**The Order of Benefit Determination**

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.
2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.
3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:
    a. **Non-Dependent/Dependent.** A Plan that covers a person other than as a Dependent will pay before a Plan that covers that person as a Dependent.
    b. **Dependent Child/Parents Not Separated or Divorced.** For a Dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the Dependent child for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, We will also use that basis.
    c. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:
    d. The Plan of the parent who has responsibility for providing insurance as determined by a court order;
        i. The Plan of the parent with custody of the child;
        ii. The Plan of the spouse of the parent with custody; and
        iii. The Plan of the parent without custody of the child.
    e. **Dependent Child/Joint Custody**. If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.
    f. **Active/Inactive Employee.** The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee's Dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
    g. **Longer/Shorter Length of Coverage.** When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

**Right to Receive and Release Needed Information**
We may release to, or obtain from, any other insurance company, organization or person information necessary for COB. This will not require the consent of, or notice to, You or any claimant. You are required to give Us information necessary for COB.

**Right to Make Payments to Another Plan**
COB may result in payments made by another Plan that should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

**Right to Recovery**
COB may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made, such recovery shall only be to the extent permitted by law.

## SECTION 11 – COVERAGE PROVISIONS

We pay a benefit if an Insured Person receives Covered Services or Materials at the allowable Frequency, as shown in the Schedule of Benefits, while Their coverage under this Certificate is in force. An Insured Person may choose to receive vision care services from either an In-Network Provider or an Out-of-Network Provider. If an In-Network Provider is chosen, the Insured Person will generally incur less out-of-pocket cost (unless the Policyholder has selected an In-Network Provider Plan only.)

**In-Network Benefits**
When benefits are payable for Covered Services or Materials received from an In-Network Provider, We will pay the In-Network Provider directly, based on the In-Network benefits shown in the Schedule of Benefits. The Insured Person pays any required Copay and any charges above the covered benefits to the In-Network Provider. The In-Network Provider takes care of claims submission and administrative services.

The Copay and the Frequency for Covered Services or Materials are shown in the Schedule of Benefits.

**Out-of-Network Benefits**
If an Insured Person chooses to use an Out-of-Network Provider, You must pay the provider in full for the services and materials purchased. It is Your responsibility to send us a claim by submitting the itemized invoice or receipt to Us. (See the “Notice of Claim” provision.) Any Copay that applies should not be paid to the Out-of-Network Providers, as it will be deducted by Us at the time the claim is processed.

When benefits are payable for Covered Services or Materials received from an Out-of-Network Provider, We will reimburse you up to the amount of Out-of-Network benefits shown in the Schedule of Benefits.

**Covered Services or Materials**
Covered Services or Materials are shown in the Schedule of Benefits. In order to be a Covered Service or Material, the services or materials must be provided to an Insured Person:

1. to check or improve their vision condition;
2. within the allowable Frequency shown in the Schedule of Benefits; and
3. by an Ophthalmologist, Optometrist, or Optician, regardless of whether such provider is an In-Network or Out-of-Network Provider.

In no event will coverage exceed the lesser of:

1. the actual cost incurred of the Covered Services or Materials; or
2. the limits of coverage shown in the Schedule of Benefits.

**Limited Access Area**

If You live in a Limited Access Area and You receive Covered Services from an Out-of-Network Provider, We will pay the same plan allowances as if You utilized an In-Network Provider. It is important to note that You will be responsible for the difference between the billed amount and Our payment. Limited Access Area does not apply outside of the United States.

## SECTION 12 – LIMITATIONS AND EXCLUSIONS

Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit. Contact Lenses are payable in lieu of Eyeglass Lenses and Frames.

**Exclusions**

No benefits are payable for any of the following conditions, services, procedures and/or materials, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits:

1. Replacement frames and/or lenses, except at normal intervals when Covered Services or Materials are otherwise available;
2. Plano lens or non-prescription lenses or sunglasses;
3. Orthoptics, vision training and any associated supplemental testing;
4. Frame cases;
5. Low (subnormal) vision aids or aniseikonic lenses;
6. Medical and surgical treatment of the eyes except for LASIK or PRK;
7. Charges incurred after (a) the Policy ends; or (b) the Insured Person's coverage under the Policy ends, except as stated in the Policy;
8. Any eye examination or corrective eyewear required by an Employer as a condition of employment;
9. Services and materials provided by another vision plan except for Coordination of Benefits;
10. Services for which benefits are paid by Worker's Compensation;
11. Benefits provided under the employee's medical insurance except for Coordination of Benefits;
12. Groove, Drill or Notch, and Roll and Polish;
13. Two pairs of glasses, in lieu of bifocals, trifocals or progressives;
14. Coating on lenses (Factory scratch coat, anti-reflective, sunglass colors, etc.);
15. Cosmetic items;
16. Faceted lenses;
17. High-Index lenses;
18. Laminated lenses;
19. Photochromic (Transition) lenses;
20. Polaroid lenses;
21. Polished bevel lenses;
22. Polycarbonate lenses, except for Insured Members under 19;
23. Fresnel prism lenses;
24. Slab-off lenses;
25. Tints (except Pink tint #1 and #2);
26. Ultra-violet tint or coating;
27. Additional cost for contact lenses over the allowance;
28. Additional cost for a frame over the allowance;
29. Progressive lenses;
30. Prescription safety eyewear lenses;
31. Medically Necessary contact lenses;
32. Retinal screening;
33. Contact lens fitting;

No benefits are payable for services performed by a member of the Insured Person's family. Insured Person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents.

## SECTION 13 – GENERAL PROVISIONS

**Entire Contract; Changes**
The entire contract consists of:

1. the Policy;
2. this Certificate;
3. Riders, Endorsements and Amendments, if any, adding or changing the provisions of the Policy or Certificate;
4. the Application of the Policyholder; and
5. the Enrollment Form of the Insured Member, if any.

A copy of the Policyholder's Application is included with the Policy, incorporating it by reference. All statements made in the Enrollment Form by the Eligible Member, in the absence of fraud, are representations and not warranties. No statement made by an Insured Person under this Policy will be used to void insurance or deny a claim unless a copy of the statement is or has been given to that Insured Person.

No change in the Policy or this Certificate will be valid until approved by an officer of the Company. The change must be signed by an officer of the Company and attached to the Policy. No agent may change the Policy or waive any of its provisions.

**Certificates**
The Company will issue to the Policyholder, for delivery to each Insured Member, a certificate containing the principal terms of this Policy.

**New Entrants**
All new employees and dependents eligible for insurance will be added to each class for which they are eligible. Coverage is subject to enrollment requirements of the Policy.

**Conformity With State Laws**
The Policy was issued on its Effective Date in the state in which the Insured resides, noted on the Application. Any Policy provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes. If any change to state or federal law affects the Company's liability under this Policy, the Company may change this Policy, the premiums or both.

Such change:
1) will be effective as of the date of change to the state or federal law; and
2) will not be made until the Company gives the Policyholder 31 days' notice.

**Misstatements**
If any relevant fact as to an Insured Person to whom this insurance relates is found to have been misstated, the true facts will be used to determine whether Their insurance is in force under the Policy and in what amount. If the error has an effect on the Premium, an adjustment of the Premium due will be made.

**Non-Participating**
The Policy is non-participating. This means that it does not share in Our surplus earnings.

**Assignment**
No assignment of the Policy is binding upon Us unless We agree to it in writing and not until such assignment is filed with Us.

**Time Limit on Certain Defenses**
The Policy will be incontestable, except for non-payment of Premium or fraudulent misstatements, after it has been in force for three years. Nothing herein should be construed to prevent the Company from denying any claim on the basis that an individual was not eligible for coverage.

**Clerical Error**
Any clerical error by Us in keeping relevant records, or a delay in making any entry, will not void any insurance otherwise validly in force or continue insurance otherwise validly terminated. When a clerical error or delay is found, Premiums and benefits will be adjusted based on the true facts and the provisions of the Policy.

**Policyholder Required Information**
Certain facts are needed to administer the Policy. We have the right to decide which facts We need. The Policyholder is required to comply with any reasonable request for information which We deem necessary to administer the Policy. We have the right to inspect any records of the Policyholder that have a bearing on the insurance or Premium under the Policy.

**Legal Action**
No legal action may be brought against Us to recover Policy prior to the expiration date of 60 days after the required written Proof of Loss is submitted to Us. No such action may be brought more than 3 years after the time written Proof of Loss is required by the Policy to be given.

## SECTION 14– REVIEW OF CLAIM

If We send You a written statement denying Your claim in whole or in part, You may, within 60 days after Your receipt of such written statement, submit a written appeal to Us. A written decision with respect to the appeal shall be sent to You within 30 days after its receipt, unless special circumstances exist which require additional time, in which case a written decision with respect to the appeal will be sent to You as soon as possible.

Effective: 9/1/2026 – 8/31/2028
$10 Exam / $25 Materials Copay
Dependent Age: 26 (EOBM)

| **Frequency Type:** Last Date of Service | Employee | Spouse | Children |
|---|---|---|---|
| **Vision Exam** | 12 Months | 12 Months | 12 Months |
| **Lenses** | 12 Months | 12 Months | 12 Months |
| **Frames** | 12 Months | 12 Months | 12 Months |

| **Benefits:** Employee Can Select Either | VBA Participating Provider Amount Covered/Benefit (After Applicable Copay)* | Out-of-Network Max Reimbursement (Zero Copay) |
|---|---|---|
| **Vision Exam** (Glasses or Contacts) | Covered in Full | $100 |
| Retinal Screening with Exam | Copay not to exceed $39 | N/A |
| **Clear Standard Lenses** (Pair): | | |
| Single Vision | Covered in Full | $60 |
| Bifocal | Covered in Full | $80 |
| Blended Bifocal | Covered in Full | $80 |
| Trifocal | Covered in Full | $100 |
| Progressives | Partially-Covered | $100 |
| Lenticular | Covered in Full | $140 |
| Polycarbonate | Covered in Full for Persons Up to Age 19 | N/A |
| Basic Scratch Coating | Covered in Full | N/A |
| **Frame** (Wholesale Allowance) | Up to $50 | $100 |
| **-OR-** | | |
| **Elective Contacts** (in lieu of eyeglass benefits) | | |
| Material Allowance | Up to $110[A] | $110 |
| Elective Fitting Fee and Evaluation | 15% off UCR | N/A |
| **-OR-** | | |
| **Medically Necessary Contacts** | Covered in Full[B] | $450 |
| **-AND-** | | |
| Low Vision Aids (Per 24 Months. No Lifetime Max) | N/A | $650 |
| Lasik Surgery (once every 8 years) | N/A | $125 |

Where an "allowance" is shown above, the Member is responsible for paying any charges in excess of the allowance less any applicable copay.

Benefits and participation may vary by location, including, but not limited to, Costco® Optical, Pearle Vision, LensCrafters®, Target Optical®, Eyeglass World® and America's Best®.

A The allowance is applied to all services/materials associated with contact lenses, including, but not limited to, contact fitting, dispensing, cost of the lenses, etc. No guarantee the allowance will cover the entire cost of services and materials.

B Requires prior approval. May only be selected in lieu of all other material benefits listed herein.

* A $10 copayment is applied to the vision exam and a $25 copayment is applied to the total cost of the lenses and/or frames ordered from a VBA Member Doctor only. Copayments do not apply to the contact materials.

This plan is designed to cover your visual needs rather than cosmetic options.

## Additional Charges

You may incur out-of-pocket charges when selecting any of the following:

- Tinted Lenses
- Photochromic/Polarized Lenses
- Polycarbonate (covered under age 19)
- Hi-index Lenses
- Progressive (available starting at $29)
- The coating of the lens or lenses (except Basic Scratch Coating)
- A frame that costs more than the plan allowance
- Rimless Frames
- Anti-Reflective

Additionally, costs for contact lenses/services in excess of the plan's scheduled reimbursement allowances are the responsibility of the patient.

## Not Covered

The contract gives VBA the right to waive any of the plan limitations if, in the opinion of our optometric consultants, it is necessary for the patient's welfare. VBA provides no benefit for professional services or materials connected with the following:

- Orthoptics or vision training
- Non-prescription lenses
- Two pair of glasses in lieu of bifocals
- Medical or surgical treatment of the eyes
- An eye examination, or corrective eyewear, required by an employer as a condition of employment
- Services of materials provided as result of any Worker's Compensation Law or similar legislation
- Glasses and contacts during the same eligibility period

Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.

## Additional Terms and Conditions

Frame allowance is based on wholesale pricing at non-retail locations. Frame allowance, contact lens pricing and policies vary by location. Contact your provider before requesting services.

Benefits may only be used for contact lenses when selected in lieu of eyeglasses (spectacle lenses and frames). If purchased at the same time from a single provider, your plan will cover up to $110 towards the cost of contact fitting fees and contact lenses. Any provider contact lens charges that exceed this amount shall be the responsibility of the member. Members may be required to pay contact fitting fees out of pocket at some locations.

Benefits and participation may vary by location and where prohibited by state law.

LASIK benefits may be limited to no more than 50% per eye.

Exam copay is not required if benefits are used to purchase contact lenses from a single provider on the same day of the member's exam. Material copays do not apply to contact lenses.

A 15% discount off the provider's usual, customary and reasonable contact lens fitting fee may be available in some locations. Void where prohibited by law.

Benefits may only be used for medically necessary contact lenses when selected in lieu of all other materials.

Additional terms and conditions apply. Contact VBA at 412-881-4900 for more information.

## THANK YOU FOR BEING A VBA MEMBER!

At VBA, we strive to make things as simple as possible for our members. While a member card is not necessary to access your benefits, you can use your VBA member card so that you have all of your plan information handy whenever you visit your doctor's office.

### Using your in-network benefits is simple.

- Log in to the VBA Member Portal to confirm eligibility for services and materials.
- Use our online Provider Finder to search for doctors in the VBA network.
- Schedule an appointment with the provider and let the office know you have vision benefit coverage through VBA prior to receiving services or purchasing materials.
- The provider will submit all claims for covered benefits directly to VBA.
- The provider will discuss and collect any copayments and/or out-of-pocket expenses from you, if applicable.

On rare occasions, a provider may discontinue participation in our network without proper notice. While making your appointment, verify participation to avoid any inconvenience.

### Do you know all the advantages of VBA membership?

We partner with several other companies that provide services to better your health and wellness.

QualSight LASIK
TLC Laser Eye Centers

Save up to $1,100 on Custom Bladeless LASIK using Wavelight with featured in-network providers Lasik***Plus***, TLC Laser Eye Centers and The LASIK Vision Institute. Schedule your free consultation today! Call 1-877-437-6105.

Hear USA

Schedule a complimentary hearing evaluation and save over 40% on premium aids with the latest technology. Call 855-203-7979.

### Member Identification Card

vba

**p: 1-800-432-4966**
**f: 412-881-4898**

400 Lydia Street, Suite 300 | Carnegie, PA 15106
www.vbaplans.com

vba

**Looking for an in-network VBA provider?**

Use our online Provider Finder to search our network. Once you've selected your provider, let them know that you have vision benefit coverage through VBA prior to receiving services or purchasing materials.

AT VBA

# You're Our Focus

## We pride ourselves on making it easy and convenient for you to use your benefits.

We know that benefits can be difficult to figure out. We are here to help you understand your benefit coverages, learn more about the products and services available to you through your plan and find an in-network doctor.

VBA offers a vast network of providers—more than 46,000 (including optometrists, ophthalmologists and retailers). Our plans offer a large selection of lens products at all price points and discount options for covered vision products.

### Managing Your Benefits Is Simple

Explore VBA's Member Portal (**members.vbaplans.com**) for all your benefit needs:

#### VBA In-Network Provider

- Log in to the VBA Member Portal to confirm eligibility for services and materials.
- Use our online Provider Finder to search for doctors in the VBA network.
- Schedule an appointment with the provider and let the office know you have vision benefit coverage through VBA prior to receiving services or purchasing materials.
- The provider will submit all claims for covered benefits directly to VBA.
- The provider will discuss and collect any copayments and/or out-of-pocket expenses from you, if applicable.

#### Out-of-Network Provider

- Log in to the VBA Member Portal to confirm eligibility for services and materials and to confirm your plan offers out-of-network benefits.
- If your plan offers out-of-network coverage and you were eligible for benefits on the date of service, you may submit a claim to VBA for reimbursement.
- If you live in a Limited Access Area and receive covered Services from an Out-of-Network Provider, we will pay the same plan allowances as if you utilized an In-Network Provider. You will be responsible for the difference between the billed amount and our reimbursement. Restrictions and limitations apply. Contact VBA for more information.

Benefits and participation may vary by location and where prohibited by state law.

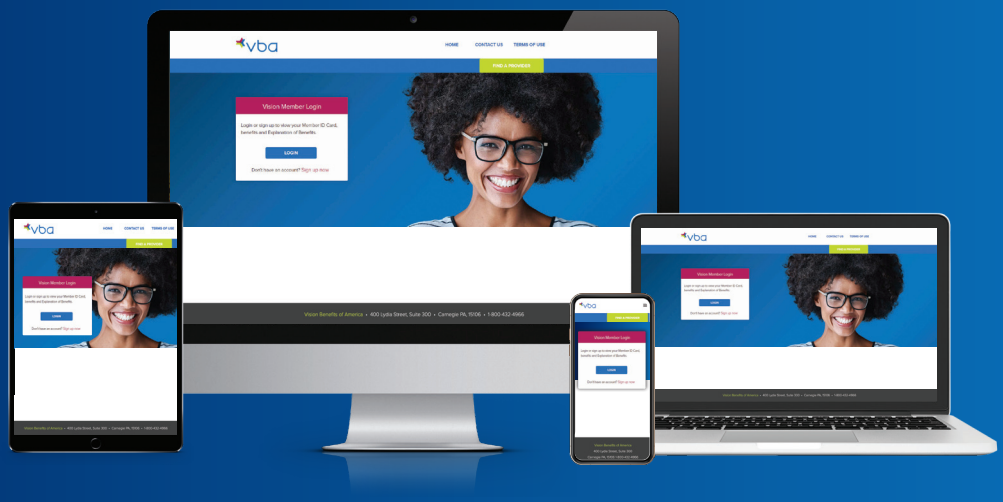
## As a VBA member, you will enjoy:

- An average distance of 3.2 miles to your first provider and 3.7 miles to your second provider.
- Access to some of the nation's top retailers including Boscov's™ Optical, Costco® Optical, LensCrafters®, Pearle Vision®, Target Optical® and Visionworks®.
- Up to $1,100 off on Custom Bladeless LASIK using Wavelight with featured in-network providers LasikPlus, TLC Laser Eye Centers and The LASIK Vision Institute. Schedule your free consultation today! Call 1-877-437-6105.
- A complimentary hearing evaluation and you can save over 40% on premium aids with the latest technology. Call 855-203-7979.
- Access to customer care representatives who are available to answer your questions by phone, email or chat.
- Answers to Frequently Asked Questions on **vbaplans.com**

400 Lydia Street, Suite 300 | Carnegie, PA 15106 | 1-800-432-4966 | www.vbaplans.com

USING THE

# VBA Member Portal



## VBA's Easy-to-Use Member Portal

At VBA, we strive to make things as simple as possible for our members. Our focus is always on you, which you'll see in every aspect of our mobile-friendly member portal. You can:

- Find in-network providers
- Chat online with customer service representatives
- Print ID cards
- Download Explanation of Benefits statements
- Submit out-of-network claims

## Access the VBA Member Portal

To create a more secure user experience, all VBA members are required to register their account before accessing the VBA Member Portal.

### Register Your Account

1. Go to vbaplans.com and click Login from the menu.
2. Select Vision and Member options and click Sign In.
3. Select Sign Up Now.
4. Enter your email address, the policyholder's birth date, zip code and last four digits of SSN or Member ID and click Send Verification Code.
5. You will receive an email with a One-Time Code from noreply@visionbenefits.com.
6. Enter your One-Time Code and click Verify Code.
7. Select Next, and access your benefits information.

### Login to Your Account

1. Go to vbaplans.com and click Login from the menu.
2. Select Vision and Member options and click Sign In.
3. Select Login.
4. Enter the email address you used to register your account and click Send Verification Code.
5. You will receive an email with a One-Time Code from noreply@visionbenefits.com.
6. Enter your One-Time Code and click Verify Code.
7. Select Next, and access your benefits information.

Each policyholder may only register their account with one email address. If your covered dependents need to access the VBA Member Portal, they must enter the registered email address and One-Time Code sent to the same email address to login.

## Did You Know?

A member card is not necessary to access your benefits. You can print your VBA member card so that you have all of your plan information handy whenever you visit your doctor's office.

You can use our online Provider Finder to search for doctors in the VBA Network.

Always confirm eligibility through the Member Portal before receiving services or purchasing materials.

## We're here to answer your questions.

Our customer care representatives are available by phone Monday through Friday 8:30 AM - 6:00 PM ET by calling 1-800-432-4966.

# Vision Benefits of America
# Notice of Privacy Practices

**NOTICE**

**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.**

This Notice outlines the ways in which Vision Benefits of America (VBA) may use and disclose protected health information about you. Protected health information (PHI) is health information that identifies a patient and relates to a patient's mental or physical condition, medical treatment, or payment for medical treatment.

We at VBA take great care to properly handle any personal health information about you and to maintain your privacy. This Notice is required by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Notice describes how VBA protects the confidentiality of your health care information in our possession. Some examples of personal health information include your name, address, telephone and/or fax number, e-mail address, social security number or other identification number, date of birth, date of vision benefit services, enrollment and other claims records. VBA receives, uses and/or discloses your personal health information to administer your vision benefit plan as permitted or required by law. Any other disclosure of your personal health information without your authorization is strictly prohibited.

VBA must follow the privacy practices described in this Notice and also comply with any more stringent requirements under federal or state law. We are also required to notify affected individuals following a breach of unsecured health information.

We will inform you of these privacy practices the first time you become a VBA member. We must follow the privacy practices described in this Notice as long as it is in effect. This Notice is effective as of September 1st, 2016, and will remain in effect unless we replace it. We reserve the right to change this Notice. We reserve the right to make the revised Notice effective for medical information we already have about you as well as any information we receive in the future. Any change to this Notice will be posted on our website. The revised Notice will contain its effective date on the first page. You may request a copy of this Notice at any time. You may contact VBA's Privacy Department with any questions or concerns regarding our privacy policies. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of this Notice.

**USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION**

**Disclosures required by HIPAA**

(i) *Disclosures to the Secretary of the U.S. Department of Health and Human Services* – We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule

(ii) *Disclosures to You* – We are required to disclose to you most of your protected health information that is in a "designated record set" (defined by HIPAA Privacy Rule) when you request access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about your vision care benefits. We are also required to provide, upon your request, an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment and health care operations.

**Permitted Uses and Disclosures**

Under HIPAA, VBA is permitted to use and disclose your personal health information for certain purposes without your prior authorization. These permitted uses and disclosures include:

(i) Disclosure to you; and

(ii) Disclosures for treatment, payment, or health care operations.

a. For example:

i. **Treatment** - We may use and disclose your personal health information to determine eligibility for vision benefit services and/or materials, or to coordinate vision benefit coverage.

ii. **Payment -** We may use and disclose your personal health information to bill you or your plan sponsor.

iii. **Health Care Operations -** We may use and disclose your personal health information to review the quality of care provided by our network providers.

VBA uses administrative, technical, and physical safeguards to maintain the privacy of your personal health information, and we are required by law to limit the use and disclosure of your personal health information to the minimum amount necessary.

**Uses and Disclosures of Personal Health Information to Other Entities**

VBA may disclose your personal health information to other covered entities, business associates, or other individuals (as permitted by HIPAA) who assist us in administering our programs and delivering services to our members. These parties are required by law to sign a contract with VBA agreeing to protect the confidentiality of your personal health information.

(i) Business Associates – In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services. To perform these services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

(ii) Plan Sponsors – If your vision benefit program is sponsored by your employer or another party, VBA may disclose your personal health information in certain instances to permit the plan sponsor to perform plan administration functions. We will make such disclosures to the plan sponsor only if the plan sponsor has certified that it has put into place plan provisions requiring the sponsor to keep the health information protected. We may also disclose "summary health information" (defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor. For example, a plan sponsor may contact us regarding members' questions or concerns regarding claims, benefits, services, coverage, etc. The plan sponsor may use this information to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

**(iii)** Health Care Providers - VBA may disclose your personal health information to participating vision care providers. These providers are required to implement their own privacy policies and procedures that comply with applicable federal and state laws.

**Other Permitted Disclosures of Personal Health Information**

Under HIPAA, VBA is permitted to use and disclose your personal health information without your prior authorization under the following conditions:

- When required by law;
- For public health activities;
- Disclosures about victims of abuse, neglect or domestic violence;
- Health oversight activities;
- Judicial and administrative proceedings (e.g. in response to court order or subpoena);
- Law enforcement, organ donation, or research purposes;
- Uses and disclosures about decedents;
- To avert a serious threat to health or safety;
- For specialized government functions (e.g. military and veterans' activities);
- Regarding workers' compensation;
- For underwriting purposes; however, we are prohibited from using or disclosing your genetic information for these purposes.

**Uses and Disclosures Requiring You to Have an Opportunity to Agree or Object**

Unless you object, VBA may disclose your protected health information to a family member, close friend, or other person you have identified as being involved in your health care. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

**Uses Requiring Your Written Authorization**
We are required to obtain your written authorization for use or disclosure of your health personal health information in the following instances:

(1) Use or disclosure of your PHI for marketing purposes;
(2) If we intend to sell your PHI; and
(3) Most uses and disclosures of psychotherapy notes.

**OTHER USES OF PERSONAL HEALTH INFORMATION**
Other uses and disclosures of personal health information not described above will be made only with your written authorization. If you provide us with such written authorization, you may revoke that authorization in writing at any time, and this revocation will be effective for future uses and disclosures of personal health information. However, the revocation will not be effective for information that we already have used or disclosed in reliance on the authorization.

**YOUR INDIVIDUAL RIGHTS**
The following is a description of your rights with respect to your Protected Health Information.

***Right to Inspect and Copy.*** *You have the right to inspect and obtain a copy of your PHI. You may access your PHI by submitting your request in writing to the privacy contact listed at the end of this Notice. You must include (1) your name, address, telephone number and identification number and (2) a description of the PHI you are requesting. VBA may charge a reasonable fee for providing you copies of your PHI. VBA only maintains the PHI that it obtains or utilizes in providing your vision care benefits.*

***Right to Request Restrictions.*** *You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations. We will consider your request but are not legally required to accept it. If VBA accepts your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and/or disclosures that VBA is legally required or allowed to make.*

***Right to Amend.*** *You have the right to correct or update your PHI. This means that you may request an amendment of your PHI for as long as VBA maintains this information. In certain cases, VBA may deny your request for amendment. If so, you have the right to file a statement of disagreement with VBA. VBA may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to VBA by another entity, we may refer you to that entity to amend your PHI (i.e., if applicable, to your employer to amend your enrollment information). Please contact VBA as noted below if you have questions about amending your PHI.*

***Right to Request Confidential Communications.*** *You have the right to request or receive confidential communications from VBA by alternative means or at a different address. VBA will agree to accommodate a reasonable request if disclosure of your PHI through standard means of communication could endanger you. You may be required to provide VBA with a written statement of possible danger, a different address, or another method of contact or information as to how payment will be handled.*

***Right to an Accounting of Disclosures.*** *You have the right to receive an accounting of certain disclosures VBA has made of your PHI. This right does not apply to disclosures for purposes of treatment, payment, or health care operations. Your request may be for disclosures made up to six (6) years before the date of your request, but in no event for disclosures made before April 14, 2003. Please contact VBA if you would like to receive an accounting of disclosures or if you have questions about this right.*

***Right to a Paper Copy of this Notice.*** *You have the right to receive a paper copy of this Notice. Even if you have agreed to receive this Notice via e-mail, you are still entitled to a paper copy. To obtain a paper copy of this Notice, please contact VBA per the information at the end of this Notice.*

**COMPLAINTS**
If you believe that any of your privacy rights have been violated, you may file a complaint with VBA. Contact our Privacy Department which will provide you with a form for your complaint, or you may obtain the complaint form from our website at www.vbaplans.com. You may complain to VBA by submitting the complaint form to us in writing, at the address or fax number provided at the end of this Notice. If you believe any of your privacy rights have been violated, you may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services at the following address:

U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Room 509F – HHH Building
Washington, D.C. 20201
Attention: Centralized Case Management Operations
(800) 368-1019
TTD number (800) 537-7697

More information about submitting a complaint to the U.S. Department of Health & Human Services is available at the following website: http://www.hhs.gov/ocr/privacy. You may also file a written complaint to VBA using the procedure listed in this section in response to a denial by us regarding any of your individual rights listed in this Notice. For example, if you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI.

***We support your right to protect the privacy of your protected health information. You will not be retaliated against in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.***

**CONTACT INFORMATION**

For questions about this Notice of Privacy Practices, or if you wish to file a complaint, please contact:

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|---|---|
| Mailing Address: | Vision Benefits of America<br>**Privacy Department**<br>400 Lydia Street, Suite 300<br>Carnegie, Pennsylvania 15106 |
| Telephone: | (412) 881-4900<br>(800) 432-4966 (toll free) |
| Fax: | (412) 881-4898 |

**NOTICE OF PROTECTION PROVIDED BY**
**PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

This notice provides a **brief summary** regarding the protections provided to policyholders by the Pennsylvania Life and Health Insurance Guaranty Association ("the Association"). This protection was created under Pennsylvania 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 member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

## COVERAGE

### Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

### Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to $300,000 (or $500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

**Life insurance:**
o Up to $300,000 in death benefits including up to $100,000 in net cash surrender or withdrawal value.

**Accident, accident and health, or health insurance (including HMOs)**:
o Up to $500,000 for health benefit plans, with some exceptions.
o Up to $300,000 for disability income benefits.
o Up to $300,000 for long-term care insurance benefits.
o Up to $100,000 for all other types of health insurance.

**Individual annuities**
o Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

## LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:
● any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

● claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
● any policy of reinsurance (unless an assumption certificate was issued);
● interest rate yields or increases based on an index that exceed an average rate specified by statute;
● dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contractholder;
● employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
● unallocated annuity contracts (which give rights to group contractholders, not individuals) other than in limited circumstances and amounts;
● certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
● policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:
● A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract
● If the person is provided coverage by the guaranty association of another state
● A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange

## NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary information provided by this notice and on the Association's web site do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's web site are for general information purposes and should not be relied upon as legal advice.