

YOUR BENEFIT PLAN

The University of Chicago Student

Vision Insurance for You and Your Dependents

Certificate Date: September 1, 2023

The University of Chicago Student
5801 S Ellis Ave
Chicago, IL 60637

TO OUR STUDENTS:

All of us appreciate the protection and security insurance provides.

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

The University of Chicago Student



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

CERTIFICATE OF INSURANCE

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

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

Policyholder: The University of Chicago Student

Group Policy Number: 249986-1-G

Type of Insurance: Vision Insurance

MetLife Toll Free Number(s):
For Claim Information FOR VISION CLAIMS: 1-833-EYE-LIFE (1-833-393-5433)

THIS CERTIFICATE ONLY DESCRIBES VISION INSURANCE.

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

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

For Residents of North Dakota: If You are not satisfied with Your Certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under Your Certificate. We will refund within 30 days of Our receipt of the returned Certificate any Premium that has been paid and the Certificate will then be considered to have never been issued. You should be aware that, if You elect to return the Certificate for a refund of premiums, losses which otherwise would have been covered under Your Certificate will not be covered.

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

NOTICE FOR RESIDENTS OF CONNECTICUT AND MINNESOTA

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

For Connecticut Residents (Vision Insurance):

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

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

For Minnesota Residents (Vision Insurance):

The term also includes:

- Your grandchildren who are financially dependent upon You and reside with You continuously from birth;
- children for whom You or Your Spouse is the legally appointed guardian; and
- children for whom You have initiated an application for adoption.

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

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

Notice Regarding Your Rights and Responsibilities

Rights:

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

Responsibilities:

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

NOTICE FOR RESIDENTS OF ARKANSAS

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

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

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

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

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

**DAVIS VISION
ATTENTION: COMPLAINTS AND APPEALS
P.O. BOX 791
LATHAM, NY 12110**

1-800-438-6388

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

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

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

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

NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

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

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

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

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

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

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

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

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

Davis Vision
Attention: Complaints and Appeals
P.O. Box 791
Latham, NY 12110

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

**Metropolitan Life Insurance Company
1-833-EYE-LIFE (1-833-393-5433)**

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

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

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

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

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

Davis Vision
Attention: Complaints and Appeals
P.O. Box 791
Latham, NY 12110
1-833-EYE-LIFE (1-833-393-5433)

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

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

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents are only covered for insurance:

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

In addition, You are eligible for Dependent Insurance only while You have Dependents who qualify.

BENEFIT

BENEFIT AMOUNTS AND HIGHLIGHTS

Provider Network:

Davis Vision Network

Vision Insurance For You and Your Dependents

	Exam	Lenses	Frame	Contacts
Service Interval	12 months	12 months	12 months	12 months

	In-Network	Out-of-Network
Exam Co-Payment <i>Co-Payment shall not apply to Retinal Imaging</i>	\$10	\$0
Materials Co-Payment <i>Co-Payment shall not apply to Contact Lenses</i>	\$25	\$0

	In-Network Coverage (Using an In-Network Vision Provider)	Out-of-Network Coverage (Using an Out-of-Network Vision Provider)	
EYE EXAMINATION (one per frequency)	Covered in full after any applicable Co-Payment Comprehensive examination of visual functions and prescription of corrective eyewear.	\$45 allowance after any applicable Co-Payment Comprehensive examination of visual functions and prescription of corrective eyewear.	
RETINAL IMAGING	Covered in full with a Co-Payment not to exceed \$39. Coverage for retinal imaging is an enhancement to eye examination. Retinal imaging is not available at all provider locations – contact your In-Network Vision Provider to see if this technology (or equipment or service) is available.	Applied to the allowance for the eye examination	
STANDARD CORRECTIVE LENSES	Covered in full after any applicable Co-Payment Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)	Single Vision	\$30 allowance
		Lined Bifocal	\$50 allowance
		Lined Trifocal	\$65 allowance
		Lenticular	\$100 allowance

SCHEDULE OF BENEFITS (continued)

	In-Network Coverage (Using an In-Network Vision Provider)		Out-of-Network Coverage (Using an Out-of-Network Vision Provider)
STANDARD LENS OPTIONS	Standard Polycarbonate (child up to age 18)	Covered in full	Applied to the allowance for the applicable corrective lens
These lens options are available with a "not to exceed" pricing/maximum member out of pocket amount. ¹	Tints/Dyes – Solid	\$15	Applied to the allowance for the applicable corrective lens
	Tints/Dyes – Gradient	Covered in full	
	Progressive – Standard	\$50	\$50allowance
	Progressive – Premium	\$90	
	Progressive – Ultra	\$140	
	Progressive – Ultimate	\$175	
	Ultra Violet Coating	\$12	Applied to the allowance for the applicable corrective lens
	Standard Polycarbonate (adult)	Covered in full	
	Scratch Resistant Coating	Tier 1 - \$0 Tier 2 - \$30	
	Anti-Reflective Coating	Tier 1 - \$35 Tier 2 - \$48 Tier 3 - \$60 Tier 4 - \$85	
	Photochromic	\$65	
	Blue Light Filtering	\$15	
	Digital Single Vision	\$30	
	Polarized	\$75	
	High Index (1.67/1.74)	\$55/\$120	
FRAMES			
DAVIS VISION NETWORK COLLECTION			Not Applicable
Fashion:	Covered in full		
Designer:	Covered in full		
Premier:	Covered in full		
NON-COLLECTION	Covered up to a \$130 allowance after any applicable Co-Payment		\$70 allowance after any applicable Co-Payment

SCHEDULE OF BENEFITS (continued)

CONTACT LENSES		
FITTING AND EVALUATION	Standard and Premium Fit: This service is available at a 15% discount	The allowance for contact lenses includes fitting and evaluation
ELECTIVE	allowance Contact lenses are provided in place of lens and frame benefits available herein.	allowance Contact lenses are provided in place of lens and frame benefits available herein.
NECESSARY	Covered in full Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's In-Network Vision Provider. Contact lenses are provided in place of lens and frame benefits available herein.	\$210 allowance Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Out-of-Network Vision Provider. Contact lenses are provided in place of lens and frame benefits available herein.
Benefit for all Providers		
REFRACTIVE SURGERY PROGRAM	Lifetime Allowance	

SUPPLEMENTAL PLAN BENEFITS	In-Network Coverage (Using an In-Network Vision Provider)	Out-of-Network Coverage (Using an Out-of-Network Vision Provider)
COVERED CONTACT LENSES	This benefit is IN ADDITION TO the standard lens and frame benefits	
	Covered in full A Co-Payment amount of shall be payable by the Covered Person at the time services are rendered.	Covered up to \$250
	The following items are not covered under the covered contact lenses enhancement: Corneal Refractive Therapy (CRT) or Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia); replacement of lost or damaged lenses; insurance policies or service agreements; plano lenses (i.e., when patient's refractive error is less than a +/- 0.50 diopter power); plano lenses to change eye color cosmetically; artistically painted lenses; additional office visits associated with contact lens pathology; contact lens modification, polishing or cleaning; and refitting after the initial (90-day) fitting period.	

¹ Not all providers participate in vision program discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if the discount and member out-of-pocket features are offered at that location. Discounts and member out-of-pocket are not insurance and subject to change without notice.

SCHEDULE OF BENEFITS (continued)

Value-Added Features Available At In-Network Vision Providers (These features are not insurance.)	
ADDITIONAL PAIR DISCOUNTS	Members may receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the providers usual and customary rate may be available. Contact lenses may be available at a 10% discount.
ADDITIONAL SAVINGS ON LENS ENHANCEMENTS	Average 20-25% savings on all lens enhancements not otherwise covered under the MetLife Vision Insurance program. ²
ADDITIONAL SAVINGS ON FRAMES	20% off any amount over your frames allowance. ²
ADDITIONAL SAVINGS ON CONTACTS	15% off any amount over your contact lens allowance. ² 15% discount on additional contacts. ²

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

DEFINITIONS

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

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

Child means the following: (for residents of Connecticut and Minnesota, the Child Definition is modified as explained in the notice pages of this certificate - please consult the Notice)

Your natural or adopted child; Your stepchild (including the child of a Domestic Partner); or a child who resides with and is fully supported by You; and who, in each case, is under age 26 and unmarried.

An adopted child includes a child placed in Your physical custody for purpose of adoption. If prior to completion of the legal adoption the child is removed from Your custody, the child's status as an adopted child will end.

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

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

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

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

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

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

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

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

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

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

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

DEFINITIONS (continued)

Domestic Partner means each of two people, one of whom is a Student of the Policyholder, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
 1. 18 years of age or older;
 2. unmarried;
 3. the sole domestic partner of the other;
 4. sharing a primary residence with the other; and
 5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by the Student.

The Religious Freedom Protection Act and Civil Union Act (750 ILCS 75) allows both same-sex and opposite-sex couples to enter into a domestic partnership with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples.

In-Network Vision Provider means an optometrist, ophthalmologist, or optician licensed and otherwise qualified to practice vision care and/or provide vision care materials who is contracted to provide Plan Benefits to Covered Persons of MetLife and accepts reimbursement at the negotiated rate.

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

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

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

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

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

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

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

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

Proof must be provided at the claimant's expense.

DEFINITIONS (continued)

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

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

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

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

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

Student means a student enrolled at The University of Chicago who is eligible for the insurance described in this certificate.

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

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

We, Us and Our mean MetLife.

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

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

You and Your mean a Student who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Students enrolled in the Vision Plan.

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

If You are in an eligible class on September 1, 2023, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after September 1, 2023, You will be eligible for insurance on the date You enter that class.

ENROLLMENT PROCESS FOR VISION INSURANCE

If You are eligible for insurance, You may enroll for such insurance by completing the required form in Writing. If You enroll for Contributory Insurance, You will be notified how much You will be required to contribute.

DATE YOUR INSURANCE TAKES EFFECT

When You complete the enrollment process for Contributory Vision Insurance, such insurance will take effect on the later of:

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

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the date You cease to be in an eligible class;
4. the end of the period for which the last premium has been paid for You;
5. the date You cease to be a Student.

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Students enrolled in the Vision Plan.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

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

If You are in an eligible class on September 1, 2023, You will be eligible for Dependent insurance on the later of:

1. September 1, 2023; and
2. the date You obtain a Dependent.

If You enter an eligible class after September 1, 2023, You will be eligible for Dependent insurance on the later of:

1. the date You enter a class eligible for insurance; and
2. the date You obtain a Dependent.

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

ENROLLMENT PROCESS FOR DEPENDENT VISION INSURANCE

If You are eligible for Dependent Insurance, You may enroll for such insurance by completing the required form in Writing for each Dependent to be insured. If You enroll for Contributory Insurance, You will be notified how much You will be required to contribute.

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

DATE VISION INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

When You complete the enrollment process for Contributory Dependent Vision Insurance, such insurance will take effect on the later of:

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

Once You have enrolled one Child for Dependent Insurance, each succeeding Child will automatically be insured for such insurance on the date the Child qualifies as a Dependent.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

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

1. the date You die;
2. the date Vision Insurance for You ends;
3. the date the Group Policy ends;
4. the You cease to be in an eligible class;
5. the date insurance for Your Dependents ends under the Group Policy;
6. the date insurance for Your Dependents ends for Your class;
7. the date You cease to be a Student;
8. the end of the period for which the last premium has been paid;
9. the date the person ceases to be a Dependent.

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

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Child attains the age limit and at reasonable intervals after such date.

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

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

CONTINUATION OF VISION INSURANCE FOR YOUR DEPENDENTS

CONTINUATION OF VISION INSURANCE FOR YOUR SPOUSE AND YOUR DEPENDENT CHILDREN

Vision Insurance for Your Dependents may be continued for an additional period of time under this provision if such coverage would otherwise end due to a Qualifying Event. For the purposes of this provision, a Qualifying Event is:

1. the dissolution of Your marriage by judgment;
2. Your death; or
3. Your retirement if your Spouse is age 55 or older on the date of Your retirement.

To continue Vision Insurance under this provision:

1. Your Spouse must notify the policyholder of the Qualifying Event within 30 days after the date of the Qualifying Event;
2. within 15 days of receipt of such notice, the policyholder must give written notice to Us of the Qualifying Event and send a copy to Your Spouse at Your Spouse's residence;
3. within 30 days of the date We receive such notice, we will send Your Spouse a form to elect to continue such coverage, and information regarding the amount of premium required to continue such coverage, and instructions for returning the election form; and
4. Your Spouse must return the election form and any required premium to the policyholder within 30 days of the date We mail the election form.

If Your Spouse fails to notify the policyholder of the Qualifying Event within 30 days of the Qualifying Event, or fails to return the election form and pay the first premium within 30 days of the date We mail the election form, eligibility to continue Vision Insurance for Your Dependents under this provision will end.

Premium for the continued coverage shall be equal to the amount charged for active Student in the class of Student to which You belong on the date of the Qualifying Event. With respect to a spouse who is age 55 or older on the date of the Qualifying Event, after Vision Insurance has been continued under this provision for 2 years, the premium may include an additional amount of up to 20 percent. Your Spouse must pay the full premium, including any contributions that You were paying and any amount that the policyholder was paying before the Qualifying Event.

Vision Insurance for Your Dependents continued under this provision will end on the earliest of the following:

1. the date Your Spouse remarries;
2. with respect to a Spouse who has not attained age 55 on the date of the Qualifying Event, the end of two years following date of the Qualifying Event;
3. if Your Spouse is not an insured employee under any other group plan on the date of election, the date on which Your Spouse becomes an insured employee under any other group plan;
4. the date Your Spouse becomes entitled to Medicare;
5. the date Vision Insurance under the policy ends for all active Students, or for the class of active Student to which You belonged before Your employment terminated;
6. if Your Spouse fails to pay a premium when due, coverage will end at the end of the grace period; or

CONTINUATION OF VISION INSURANCE FOR YOUR DEPENDENTS (continued)

CONTINUATION OF VISION INSURANCE FOR YOUR SPOUSE AND YOUR DEPENDENT CHILDREN (Continued)

7. if the coverage is being continued under this provision because of Your death or the dissolution of Your marriage, the date coverage would end under the group policy if You and Your Spouse were still married, except that unless such coverage is ending for all Students, such coverage will not end until 120 consecutive days after the date of the Qualifying Event.

If Vision Insurance for Your Dependents may be continued:

- under this provision; and
- any other provision of this policy

all such continuation periods will be deemed to run concurrently with each other and shall not be deemed to run consecutively.

CONTINUATION OF INSURANCE FOR YOUR DEPENDENT CHILDREN

Vision Insurance for Your Dependent Child may be continued for an additional period of time under this provision if:

- such coverage would otherwise end due to Your death and Your Dependent Child is not eligible for coverage under the subsection entitled CONTINUATION OF VISION BENEFITS FOR YOUR SPOUSE AND YOUR DEPENDENT CHILDREN; or
- Your Dependent Child has attained the limiting age.

To continue Vision Insurance in the event of Your death:

1. Your Dependent Child or the responsible adult acting on behalf of Your Dependent Child must provide written notice to the policyholder of Your death within 30 days of the date on which the coverage would otherwise end;
2. within 15 days of receipt of such notice, the policyholder must give written notice to Us of Your death and Your Dependent Child's residence and send a copy to Your Dependent Child or the responsible adult of Your Dependent Child at Your Dependent Child's residence;
3. within 30 days of the date We receive such notice from the policyholder, Your Dependent Child, or the responsible adult acting on behalf of Your Dependent Child, we will send by certified mail, return receipt requested, to Your Dependent Child or the responsible adult acting on behalf of Your Dependent Child:
 - a form to elect to continue such coverage;
 - information regarding the amount of premium required to continue such coverage; and
 - instructions for returning the election form; and
4. Your Dependent Child or the responsible adult acting on behalf of Your Dependent Child must return the election form and any required premium to the policyholder within 30 days of the date We mail the election form.

To continue Vision Insurance in the event Your Dependent Child attains the limiting age:

1. Your Dependent Child must provide written notice to the policyholder of the attainment of the limiting age of Your Dependent Child within 30 days of the date on which the coverage would otherwise end;
2. within 15 days of receipt of such notice, the policyholder must give written notice to Us of the attainment of the limiting age of Your Dependent Child and Your Dependent Child's residence;

CONTINUATION OF VISION INSURANCE FOR YOUR DEPENDENTS (continued)

CONTINUATION OF INSURANCE FOR YOUR DEPENDENT CHILDREN (Continued)

3. within 30 days of the date We receive such notice from the policyholder, Your Dependent Child, or the responsible adult acting on behalf of Your Dependent Child, we will send by certified mail, return receipt requested, to Your Dependent Child or the responsible adult acting on behalf of Your Dependent Child:
4. Your Dependent Child must return the election form and any required premium to the employer within 30 days of the date We mail the election form.

Eligibility for Your Dependent Child to continue Vision Insurance under this provision will end if Your Dependent Child or the responsible adult acting on behalf of Your Dependent Child:

1. fails to notify the employer within 30 days of the date of:
 - Your death; or
 - the attainment of Your Dependent Child's limiting age;
2. fails to return the election form within 30 days of the date We mail the election form; or
3. fails to pay the required premium within 30 days of the date We mail the election form.

Notwithstanding any other provision of the policy, if We fail to notify Your Dependent Child or the responsible adult acting on behalf of Your Dependent Child of this continuation provision, all premiums will be waived from the date the notice was required until the date the notice was sent. The Vision Insurance will be continued under the terms and provisions of the policy, from the date the notice was required until the date the notice was sent, except where the Vision Insurance in existence at the time Our notice was to be sent in accordance with this section has ended for all Students.

Premium for the continued coverage shall be equal to the sum of:

- the amount charged for active Students in the class of Students to which Your Dependent Child belonged on the date of Your death or Your Dependent Child's attainment of the limiting age; and
- any amount that the policyholder would pay toward the premium if You were a current Student and Your Dependent Child had not attained the limiting age.

Vision Insurance for Your Dependent Child continued under this provision will end on the earliest of the following:

1. if Your Dependent Child or the responsible adult acting on behalf of Your Dependent Child fails to pay a premium when due, coverage will end at the end of the grace period;
2. the date Vision Insurance under the policy ends for all active Students, or for the class of active Student to which You belonged before Your employment terminated;
3. if Your Dependent Child is not an insured employee under any other group plan on the date of election, the date on which Your Dependent Child becomes an insured employee under any other group plan; or
4. the end of two years following the date the continuation provision in this section began.

If Your Dependent Child is eligible to continue Vision Insurance under this provision and any other provision of the policy, all such continuation periods will be deemed to run concurrently with each other and shall not be deemed to run consecutively.

VISION INSURANCE

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

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

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

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

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

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

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

You can obtain a customized listing of MetLife's In-Network Vision Providers either by calling 1-833-EYE-LIFE (1-833-393-5433) or by visiting Our website at www.metlife.com/mybenefits.

PLAN BENEFITS

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

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

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

In-Network

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

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

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

VISION INSURANCE (continued)

Out-of-Network

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

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

Necessary Contact Lenses

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

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

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

VISION INSURANCE: DESCRIPTION OF COVERED SERVICES AND MATERIALS

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

1. One complete visual examination, if indicated as a Covered Service on the SCHEDULE OF BENEFITS. Dilation is included as a Covered Service when provided by an In-Network Vision Provider.
2. Standard corrective lenses. We will cover a pair of standard single vision, lined bifocal, lined trifocal or lenticular lenses that are necessary to correct vision. Standard corrective lenses are as follows:
 - eyesizes up to and including 60mm;
 - multi-focal lenses in all segment widths;
 - prism and slab off;
 - base curves (regardless of curve);
 - lenses with the combined power in any meridian is +/- .50 diopters or greater in at least one eye; and
 - plastic or glass lenses.
3. The following lens options described in the SCHEDULE OF BENEFITS: tint (solid and gradient), standard plastic scratch coating, standard polycarbonate (if you are less than 18 years of age), standard anti-reflective coating, plastic photochromic, blue light filtering, digital single vision, polarized, high index (1.67/1.74).
4. Contact lenses.
 - A standard fitting and 1 follow-up visit by a Vision Provider.
 - The following contact lenses options, as described in the SCHEDULE OF BENEFITS: conventional, disposable, and Necessary.
5. Necessary low vision aids.
6. We do not cover costs above the Maximum Benefit Allowance shown in the SCHEDULE OF BENEFITS for frames. If frames are selected that are more expensive than that amount, You will be charged the difference between the Maximum Benefit Allowance and the Vision Provider's charge for the more expensive frame.
7. Necessary contact lenses in lieu of all benefits for vision materials.

VISION INSURANCE: EXCLUSIONS

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

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

VISION INSURANCE: SUPPLEMENTAL PLAN BENEFIT: COVERED CONTACT LENSES

PLAN BENEFITS

The Covered Contact Lenses benefit enhances standard vision plans to allow Covered Persons to obtain elective contact lenses with fitting and evaluation in addition to the standard spectacle lenses and frame benefit.

A Co-payment is required for professional services related to the fitting of contact lenses and is not refundable to the Covered Person regardless of whether or not the fitting is successful.

In-Network

The Covered Person must pay a Co-payment amount of \$50 at the time services are rendered. After payment of the Co-payment, the cost of elective contact lenses are covered in full.

Out-of-Network

Elective contact lenses are covered up to \$250 allowance.

EXCLUSIONS

The following items are not covered:

1. Corneal Refractive Therapy (CRT) or Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia);
2. Replacement of lost or damaged lenses;
3. Plano lenses to change eye color cosmetically;
4. Artistically painted lenses; and
5. Additional office visits associated with contact lens pathology.

VISION INSURANCE: FILING A CLAIM

CLAIMS FOR VISION INSURANCE

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

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

Out of network claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-833-EYE-LIFE (1-833-393-5433). Vision claim forms can also be downloaded from www.metlife.com/mybenefits. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

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

CLAIMS FOR VISION INSURANCE BENEFITS

When a claimant files a claim for Vision Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 180 days from the date of service.

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

Step 1

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

Step 2

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

Step 3

The claimant must give Us Proof not later than 180 days from the date of service.

VISION INSURANCE: PROCEDURES FOR VISION CLAIMS

Routine Questions on Vision Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-833-EYE-LIFE (1-833-393-5433).

Claim Denial Appeals

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

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

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

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

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

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

GENERAL PROVISIONS

Assignment

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

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

Vision Insurance: Who We Will Pay

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

Entire Contract

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

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

Incontestability: Statements Made by You

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

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

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

Conformity with Law

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

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



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

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

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

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

SECTION 2: Protecting Your Information

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

SECTION 3: Collecting Your Information

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

SECTION 4: How We Get Your Information

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

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

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

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

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

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

Another source of information is MIB, Inc. ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's

file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: Using Your Information

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

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

SECTION 6: Sharing Your Information With Others

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

Other reasons we may share your information include:

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

SECTION 7: HIPAA

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

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

SECTION 8: Accessing and Correcting Your Information

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

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

SECTION 9: Questions

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

Send privacy questions to:

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

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

HIPAA Notice of Privacy Practices for Protected Health Information

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

PLEASE REVIEW IT CAREFULLY.

Dear MetLife Customer:

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

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

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

NOTICE SUMMARY

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

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

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

In addition, we may use or disclose PHI:

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

You have the right to:

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

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

We are required by law to:

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

NOTICE DETAILS

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

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

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

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

- **For Payment:** We may use and disclose PHI to pay benefits under your Coverage. For example, we may review PHI contained in claims to reimburse providers for services rendered. We may also disclose PHI to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose PHI to a health plan or an administrator of an employee welfare benefit plan for various payment-related functions, such as eligibility determination, audit and review, or to assist you with your inquiries or disputes.

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

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

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

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

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

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

- **For Health-Related Benefits or Services:** We may use your PHI to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about health-related products or services that may be of

interest to you. However, we will not send marketing communications to you in exchange for financial remuneration from a third party without your authorization.

- **For Law Enforcement or Specific Government Functions:**

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

- **When Requested as Part of a Regulatory or Legal Proceeding:**

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

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

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

Your Rights Regarding Protected Health Information That We Maintain About You

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

- **Right to Inspect and Copy Your PHI:** In most cases, you have the right to inspect and obtain a copy

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

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

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

- **Right to a List of Disclosures:** You have the right to request a list of the disclosures we have made of your PHI. This list will not include disclosures made for treatment, payment, health care operations, purposes of national security, to law enforcement, to corrections personnel, pursuant to your authorization, or directly to you. To request this list, you must submit your request in writing. Your request must state the time period for which you want to receive a list of disclosures. You may only request an accounting of disclosures for a period of time less than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any cost.

- **Right to Request Restrictions:** You have the Right to request a restriction or limitation on PHI we

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

- **Right to Request Confidential**

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

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

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

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

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

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

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

ADDITIONAL INFORMATION

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

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

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

Uniformed Services Employment And Reemployment Rights Act

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

Continuation of Group Vision Insurance:

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

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

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

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

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

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

