

UnitedHealthcare Vision
UnitedHealthcare Insurance Company
Certificate of Coverage

For

St of NC State Retirement Services

GROUP NUMBER: 708788

EFFECTIVE DATE: January 1, 2014

UnitedHealthcare Insurance Company

Group Vision Care Certificate of Coverage

Issued To: St of NC State Retirement Services ("Enrolling Group")
Policy Number: 708788
Policy Effective Date: January 1, 2014
Policy Anniversary Date: January 1

This *Certificate of Coverage* ("*Certificate*") sets forth your rights and obligations as a Covered Person. It is important that you READ YOUR *CERTIFICATE* CAREFULLY and familiarize yourself with its terms and conditions.

The Policy may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost a Subscriber must pay can be obtained from the Enrolling Group.

UnitedHealthcare Insurance Company (the "Company") agrees with the Enrolling Group to provide coverage for Services to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued on the basis of the Enrolling Group's application and payment of the required Policy Charges. The Enrolling Group's application is made a part of the Policy.

Many words used in this *Certificate* and the attached *Table of Benefits* have special meanings. These words will appear capitalized and are defined for you in *Section 1: Definitions*. By reviewing these definitions, you will have a clearer understanding of your *Certificate* and *Table of Benefits*.

When we use the words "we", "us", "our", and "the Company" in this *Certificate*, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your", we are referring to the people who are Covered Persons as the term is defined in *Section 1: Definitions*.

The Policy is delivered in and governed by the laws of the State of North Carolina.

Read your Certificate Carefully

This is a legal contract between the policyholder and the Company.

This Certificate is not a Medicare Supplement Certificate. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from the Company.

Important Cancellation Information. Please read the provision entitled "Termination of Coverage" in Section 3 of this Certificate.

Group Vision Care Certificate of Coverage

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Section 1: Definitions

Copayment - The charge, in addition to the Premium, that you are required to pay to a Network Provider for certain Services payable under the Policy. You are responsible for the payment of any Copayment directly to the provider of the Service at the time of service, or when billed by the provider. The negotiated fee shall base deductibles or copayments on the negotiated fee or the ordinary charge if less than the negotiated fee.

Covered Person - The Subscriber or an Enrolled Dependent but this term applies only while the person is enrolled under the Policy. Reference to "you" and "your" throughout this *Certificate* are references to Covered Persons.

Covered Contact Lens Selection - A selection of available contact lenses that may be obtained from a Network Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Covered Eyeglass Frames Selection - A selection of available eyeglass frames that may be obtained from a Network Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Dependent - (1) the Subscriber's legal spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. or (2) a dependent child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, a legally adopted child, a child placed for adoption, a foster child from the moment of placement in the home, or a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse). The term child also includes a grandchild of either the Subscriber or the Subscriber's spouse. The definition of Dependent is subject to the following conditions and limitations:

- A. The term Dependent will not include any dependent child 26 years of age or older, except as stated in *Section 3: Termination of Coverage, sub-section 3.2 Extended Coverage for Handicapped Dependent Children*.

The Subscriber agrees to reimburse the Company for any Vision Services provided to the child at a time when the child did not satisfy these conditions.

The term Dependent also includes a child for whom vision care coverage is required through a Qualified Medical Child Support Order or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

The term "foster child" means a minor (i) over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or (ii) the primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

The term "placement in the foster home" means physically residing with a person appointed as guardian or custodian of a foster child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the foster child with the intent that the foster child reside with the guardian or custodian on more than a temporary or short-term basis.

The term Dependent does not include anyone who is also enrolled as a Subscriber, nor can anyone be a Dependent of more than one Subscriber.

Domestic Partner - A person of the opposite or same sex with whom the Subscriber has established a Domestic Partnership. In no event will a person's legal spouse be considered a Domestic Partner.

Domestic Partnership - A relationship between the Subscriber and one other person of the opposite or same sex. The following requirements apply to both persons:

- They share the same permanent residence and the common necessities of life;

- They are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which they reside;
- Each is at least 18 years of age;
- Each is mentally competent to consent to contract;
- Neither is currently married to another person under either a statutory or common law;
- They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:
 - Have a single dedicated relationship of at least 6 months duration.
 - Joint ownership of residence.
 - At least two of the following:
 - ◆ Joint ownership of an automobile.
 - ◆ Joint checking, bank or investment account.
 - ◆ Joint credit account.
 - ◆ Lease for a residence identifying both partners as tenants.
 - ◆ A will and/or life insurance policies which designates the other as primary beneficiary.
- The Subscriber and Domestic Partner must jointly sign an affidavit of Domestic Partnership.

Eligible Person - A person who meets all applicable eligibility requirements for vision care coverage.

Employee - a nonseasonal person who works on a full time basis, with a normal work week of 0 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part time, temporary, or substitute basis.

Enrolled Dependent - A Dependent who is properly enrolled for coverage under the Policy.

Enrolling Group - The employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental, Investigational or Unproven Services - Medical, vision, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

- A. Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- B. Subject to review and approval by any institutional review board for the proposed use; or
- C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- D. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Foreign Services - Services provided outside the U.S. and U.S. Territories.

Network Benefits - Coverage for Services provided by a Network Provider.

Non-Network Benefits - Coverage for Services provided by a provider other than a Network Provider.

Network Provider - Any optometrist, ophthalmologist, optician or other person who may lawfully provide Services who has contracted, directly or indirectly, with us, to provide Services to Covered Persons participating in our vision plans.

Non-Network Provider - Any optometrist, ophthalmologist, optician or other person who may lawfully provide Services to Covered Persons.

Plan Year - A period of time beginning with the Policy Anniversary Date of any year and terminating exactly one year later. If the Policy Anniversary Date is February 29, such date will be considered to be February 28 in any year having no such date.

Policy - The Group Vision Care Insurance Policy issued to the Enrolling Group.

Premium - The periodic fee required to maintain coverage of Covered Persons in accordance with the terms of the Policy.

Service - Any covered benefit listed in *Section 4: Benefits* of this *Certificate*.

Subscriber - An Eligible Person who is properly enrolled for coverage under the Policy and is the person on whose behalf the Policy is issued to the Enrolling Group.

Section 2: Eligibility and Effective Dates

Effective Date of Coverage

In no event is there coverage for Services rendered or delivered before the effective date of coverage. Coverage will be effective subject to any applicable waiting period required by the Enrolling Group.

Enrollment

Eligible Persons may enroll themselves and their Dependents for coverage under the Policy during any enrollment period by submitting a form provided or approved by the Company. In addition, new Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for coverage under the Policy.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

Coverage for a Newly Eligible Person

Coverage for you and any of your Dependents will take effect on the date agreed to by the Enrolling Group and the Company. Coverage is effective only if the Company receives any required Premium and a properly completed enrollment form within 90 days after the first day of employment.

Coverage for a Newly Eligible Dependent

Coverage for a new Dependent acquired by legal guardianship, court or administrative order, or marriage will take effect on the date of the event. Coverage is effective only if the Company receives any required Premium and is notified of the event within 31 days. Enrollment periods will be waived for court ordered dependents.

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption or foster home will be effective upon the date of birth or the date of placement in the adoptive/foster home. If additional monthly premiums are required, you must notify the Company and pay the required premium within 31 days of acquiring the new Dependent. If no additional monthly premium will be required, a newborn child will be covered from the moment of birth. A foster care or adopted child will be covered from the date of placement in the home provided coverage for that child is put into effect within 31 days.

Section 3: Termination Provisions

Termination of Coverage

A Covered Person's coverage, including coverage for Services rendered after the date of termination for conditions arising prior to the date of termination, will automatically terminate on the earliest of the dates specified below:

1. The date the entire Policy is terminated for the reasons specified in the Policy. The Enrolling Group is responsible for notifying the Subscriber 45 days in advance of the termination of the Policy.
2. The date the Covered Person ceases to be an Eligible Person.
3. The date requested in such notice when the Company receives written notice from either the Subscriber or the Enrolling Group instructing the Company to terminate coverage of the Subscriber or any Covered Person.
4. The date the Subscriber is retired or pensioned under the Enrolling Group's plan, unless a specific coverage classification is specified for retired or pensioned persons in the Enrolling Group's application and the Subscriber continues to meet any applicable eligibility requirements.

When any of the following apply, the Company will provide written notice of termination to the Subscriber 45 days in advance of the termination of the Policy:

5. The date specified by the Company that all coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided the Company with false material information. Such information may include, but is not limited to, information relating to residence, information relating to another person's eligibility for coverage or status as a Dependent. The Company has the right to rescind coverage back to the Policy Effective Date.
6. The date specified by the Company that coverage will terminate due to material violation of the terms of the Policy.
7. The date specified by the Company that, unless the Company has begun legal proceedings against the Covered Person, the Covered Person's coverage will terminate because the Covered Person has committed acts of physical or verbal abuse that pose a threat to the Company's staff, a provider, or other Covered Persons.
8. The date specified by the Company that all coverage will terminate because the Covered Person permitted the use of his or her ID card by any unauthorized person or used another person's card.
9. The date specified by the Company that your coverage will terminate because the Subscriber failed to pay a required Premium.

If covered Services are in progress on the date which coverage terminates, such Services will be completed, except where termination is due to fraud, misrepresentation, material violation of the terms of the Policy, failure to pay required Premiums, or acts of physical or verbal abuse. If the termination is due to fraud, no statement made by the Enrolling Group will be used to void this Policy after it has been in force for a period of 2 years.

Reimbursement for Services

The Covered Person will be responsible for any claims paid by the Company when coverage was provided in error, except where that error was made by the Company.

Extended Coverage for Handicapped Dependent Children

Coverage of an unmarried Enrolled Dependent who is incapable of self-support because of mental retardation or physical handicap will be continued beyond the limiting age provided that:

- A. The Enrolled Dependent becomes so incapacitated prior to attainment of the limiting age;
- B. The Enrolled Dependent is chiefly dependent upon the Subscriber for support and maintenance;
- C. Proof of such incapacity and dependence is furnished to the Company within 31 days of the date the Subscriber receives a request for such proof from the Company; and
- D. Payment of any required contribution for the Enrolled Dependent is continued.

Coverage will continue so long as the Enrolled Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Policy. Before granting this extension, the Company may reasonably require that the Enrolled Dependent be examined at the Company's expense by a physician designated by the Company. At reasonable intervals, the Company may require satisfactory proof of the Enrolled Dependent's continued incapacity and dependency, including medical examinations at the Company's expense. Such proof will not be required more often than once a year. Failure to provide such satisfactory proof within 31 days of the request by the Company will result in the termination of the Enrolled Dependent's coverage under the Policy.

Section 4: Benefits

You will be provided with benefits for each of the listed Services as stated in the *Table of Benefits*. Your rights to benefits are subject to the terms, conditions, and exclusions of the Policy, including this *Certificate*, and any attached Amendments.

Obtaining Services

To find a Network Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Network Providers on the Internet at www.myuhcvision.com.

Covered services, with exception to preventive care, will be covered in or out of network.

Foreign Services

Foreign Services will be treated as Non-Network benefits under this Policy. Payments will be made in U.S. currency and dispersed to the U.S. address of the Subscriber. The Company makes no guarantee on value of payment and will not protect against currency risk. Currency valuations for payment liability will be based on exchange rates published in the Wall Street Journal on the date the claim is processed.

Section 5: Benefit Descriptions

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

Eyeglass Frames

A structure that contains eyeglasses lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

Optional Lens Extras

Special lens stock or modifications to lenses that do not correct visual acuity problems. Optional Lens Extras include options such as, but not limited to, tinted lenses, polycarbonate lenses, transition lenses, high-index lenses, progressive lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photochromatic coating.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Necessary Contact Lenses

This benefit is available where a provider has determined a need for and has prescribed the service. Such determination will be made by the provider and not by us.

Contact lenses are necessary if the Covered Person has:

1. Keratoconus;
2. Anisometropia;
3. Irregular corneal/astigmatism;
4. Aphakia;
5. Facial deformity; or
6. Corneal deformity.

Section 6: General Provisions

Legal Actions

No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Amendments and Alterations

Amendments to the Policy are effective upon 31 days written notice to the Enrolling Group. Riders are effective on the date specified by the Company. No change will be made to the Policy unless it is made by an Amendment or a Rider that is signed by an officer of the Company. No agent has authority to change the Policy or to waive any of its provisions.

Time Limit on Certain Defenses

No statement made by the Enrolling Group will be used to void this Policy after it has been in force for a period of 2 years.

Relationship Between Parties

The relationships between the Company and providers, and the relationship between the Company and the Enrolling Group, are solely contractual relationships between independent contractors. Providers and the Enrolling Group are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of providers or of the Enrolling Group.

The relationship between a provider and any Covered Person is that of provider and patient. The provider is solely responsible for the services provided by it to any Covered Person. The Enrolling Group is solely responsible for enrollment and coverage classification changes (including termination of a Covered Person's coverage through the Company) and for the timely payment of the Policy Charge.

Assignment of Benefits

No assignment of the benefits or of payment for reimbursement is binding unless agreed to in writing. Such agreement is not valid until approved by us.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive you of coverage under the Policy. A clerical error also does not create a right to benefits.

Notice

When the Company provides written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons.

Workers' Compensation Not Affected

The coverage provided under the Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

Conformity with Statutes

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Waiver/Estoppel

Nothing in the Policy, *Certificate* or *Table of Benefits* is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy, *Certificate* or *Table of Benefits*, or to exercise any option which is herein provided, shall in no way be construed to be a waiver of such provision of the Policy, *Certificate* or *Table of Benefits*. State mandated items may not be waived.

Headings

The headings, titles and any table of contents contained in the Policy, *Certificate* or *Table of Benefits* are for reference purposes only and shall not in any way affect the meaning or interpretation of the Policy, *Certificate* or *Table of Benefits*.

Unenforceable Provisions

If any provision of the Policy, *Certificate* or *Table of Benefits* is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Policy, *Certificate* or *Table of Benefits* to the greatest extent legally permissible.

Reinstatement

If any renewal premium is not paid within the time granted to you for payment, a subsequent acceptance of premium by the Company or by an agent duly authorized by the Company to accept such premium shall reinstate the Certificate; provided however, that if the Company or such agent received an application for reinstatement and issued a conditional receipt for the premium tendered. The Certificate will be reinstated upon approval of such application by the Company, or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the Company has previously notified you in writing of its disapproval of the application. The reinstated Certificate will cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than 10 days after such date. In all other respects the insured and the Company will have the same rights as they had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

Section 7: Claims

Proof of Loss

Notice of claim as determined by us must be given to us within 180 days of the date such loss begins. The notice must be given with sufficient information to identify the Covered Person. Failure to file such notice within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, the notice must be given as soon as reasonably possible.

Payment of Claims

When obtaining Services from a Network Provider, you will be required to pay a Copayment and any charges not covered by the Policy to your Provider. When obtaining Services from a Network Provider, you will not be required to submit a claim form.

When obtaining Services from a non-Network Provider, you will be required to pay all billed charges to your provider. You may then obtain reimbursement from us for the covered portion of Services.

Time of Payment of Claims

Indemnities payable under this Policy for any loss other than loss for which this Policy provides any period payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this Policy provides periodic payment will be paid monthly, and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Reimbursement

To file a claim for reimbursement for Services rendered by a non-Network Provider, or for Services covered as reimbursements (whether or not rendered by a Network Provider or a non-Network Provider), provide the following information on claim form acceptable to the Company:

1. Your itemized receipts;
2. Subscriber name;
3. Subscriber's identification number;
4. Patient name; and
5. Patient date of birth.

Submit the above information to us:

By mail:

Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Reimbursements are payable in accordance with any state prompt pay requirements after the Company receives acceptable proof of loss.

Examination of Covered Persons

In the event of a question or dispute concerning coverage for vision Services, the Company may reasonably require that a Covered Person be examined at the Company's expense by a Network Provider acceptable to the Company.

Section 8: Complaint Procedures

Complaint Resolution

If you have a concern or question regarding the provision of Services or benefits under the Policy, you should contact the Company's customer service department. Customer service representatives are available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A customer service representative will return your call. If you would rather send your concern to us in writing at this point, the Company's authorized representative can provide you with the appropriate address.

If the customer service representative cannot resolve the issue to your satisfaction over the phone, he or she can provide you with the appropriate address to submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

If you disagree with our decision after having submitted a written complaint, you can ask us in writing to formally reconsider your complaint. If your complaint relates to a claim for payment, your request should include:

The patient's name and identification number.

The date(s) of service(s).

The provider's name.

The reason you believe the claim should be paid.

Any new information to support your request for claim payment.

We will notify you of our decision regarding our reconsideration of your complaint within 60 days of receiving it. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Complaint Hearing

If you request a hearing, we will appoint a committee to resolve or recommend the resolution of your complaint. If your complaint is related to clinical matters, the Company may consult with, or seek the participation of, medical and/or vision experts as part of the complaint resolution process.

The committee will advise you of the date and place of your complaint hearing. The hearing will be held within 60 days following the receipt of your request by the Company, at which time the committee will review testimony, explanation or other information that it decides is necessary for a fair review of the complaint.

We will send you written notification of the committee's decision within 30 days of the conclusion of the hearing. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Section 9: Refund of Expenses

Refund of Overpayments

If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if:

- A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- B. All or some of the payment made by the Company exceeded the benefits under the Policy; or
- C. All or some of the payment was made in error.

The refund equals the amount the Company paid in excess of the amount it should have paid under the Policy.

If the Covered Person does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Enrolling Group. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Section 10: Exclusions

The following Services and materials are excluded from coverage under the Policy:

1. Non-prescription items (e.g. Plano lenses).
2. Services that the Covered Person, without cost, obtains from a governmental organization or program, except that no health insurer shall take into account that the Covered Person is eligible for, or is provided medical assistance in this or any other state under 42 U.S.C. §1396a (section 1902 of the Social Security Act) in insuring that Covered Person, or making payments under its health benefit plan for benefits to that Covered Person or on that individual's behalf.
3. Services for which the Covered Person are paid under Workers' Compensation Law, or other similar employer liability law.
4. Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.
5. Medical or surgical treatment for eye disease, which requires the services of a physician.
6. Replacement or repair of lenses and/or frames that have been lost or broken.
7. Optional Lens Extras not listed in the *Table of Benefits*.
8. Missed appointment charges.
9. Applicable sales tax charged on Services.
10. Services that are not specifically covered by the Policy.
11. Procedures that are considered to be Experimental, Investigational or Unproven. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

Group Vision Care Table of Benefits

Third Party Administrator: Spectera, Inc.

Claim Administrator: UnitedHealthcare Insurance Company, 6220 Old Dobbin Lane, Columbia, MD 21045. Telephone No. 1-800-839-3242

The following Services will be covered in full, subject to a Copayment, when obtained from Network Providers.

When obtaining these Services from a Network Provider, you will be required to pay a Copayment at the time of service for certain Services. The amount of Copayment that a Network Provider will charge is as noted in the column "Copayment at a Network Provider" in the chart below.

When obtaining these Services from a non-Network Provider, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts noted in the column "Non-Network Benefit" in the chart below.

Differentials in Copayment percentages which are applicable to benefit levels for services provided by Network and Non-Network providers may not exceed 30%.

SERVICE	FREQUENCY OF SERVICE	COPAYMENT AT A NETWORK PROVIDER	NON-NETWORK BENEFIT
Eyeglass Frames	Once every 24 months ¹	\$10.00 ² from the Covered Eyeglass Frames Selection ³	Up to \$50.00
Eyeglass Lenses	Once every 12 months ¹		
• Single Vision		\$10.00 ²	Up to \$40.00
• Bifocal		\$10.00 ²	Up to \$60.00
• Trifocal		\$10.00 ²	Up to \$80.00
• Lenticular		\$10.00 ²	Up to \$80.00
Contact Lenses	Once every 12 months ¹	\$10.00 (up to 4 boxes from the Covered Contact Lens Selection) ⁴	Up to \$125.00
• Necessary		\$10.00	Up to \$210.00

Optional Lens Extras:

- Eyeglass Lenses: The following Optional Lens Extras are covered in full:
 - Standard scratch-resistant coating
 - Ultraviolet coating
 - Tinted lenses
 - Polycarbonate Lenses

- Standard progressive lenses
- Deluxe progressive lenses

¹You are eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you select more than one of these Services, only one Service will be covered.

²If you purchase Eyeglass Lenses and Eyeglass Frames at the same time from the same Network Provider, only one Copayment will apply to those Eyeglass Lenses and Eyeglass Frames together.

³You may purchase from your Network Provider Eyeglass Frames that are outside of the Covered Eyeglass Frames Selection. Non-selection Eyeglass Frames will receive an allowance. The Eyeglass Frame allowance will be \$50.00 wholesale or \$130.00 retail, depending upon the type of Network Provider selected. No Copayment will apply to non-selection Eyeglass Frames.

⁴You may purchase from your Network Provider Contact Lenses that are outside of the Covered Contact Lens Selection. Non-selection Contact Lenses will receive an allowance of \$125.00. No Copayment will apply to non-selection Contact Lenses. Coverage for Covered Contact Lens Selection will not apply at Walmart, Sam's Club and Costco locations. The allowance for Non-selection Contact Lenses will be used.

UNITEDHEALTHCARE VISION

NOTICE OF PRIVACY PRACTICES

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.

Effective: April 14, 2003

We* are required by law to protect the privacy of your health information. We are also required to send you this notice which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that related to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our web site www.myuhcvision.com.

*For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following UnitedHealthcare entities: ACN Group of California, Inc.; All Savers Insurance Company; AmeriChoice of New Jersey, Inc.; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Dental Benefit Providers of California, Inc.; Dental benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Dental Benefit Providers of New Jersey, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; Investors Guaranty Life Insurance Company; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Nevada Pacific Dental, Inc.; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Optimum Choice, Inc. of Pennsylvania; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; Pacific Union Dental, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc., UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Tennessee, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of Ohio; and U.S. Behavioral Health Plan, California.

How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- **For Payment** of premiums due us and to process claims for health care services you receive.
- **For Treatment.** We may disclose health information to your doctors or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws of job-related injuries.

- **Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

If none of the above reasons apply, **then we must get your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, refer to "Exercising Your Rights" on page 4 of this notice.

Highly Confidential Information

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;
- Sexually transmitted diseases and reproductive health information; and
- Child or adult abuse or neglect, including sexual assault.

Attached to this notice is a *Summary of State Laws on Use and Disclosure of Certain Types of Medical Information.*

What Are Your Rights

The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address).
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.

- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.myuhcvision.com

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

UnitedHealthcare
Customer Service - Privacy Unit
PO Box 740815
Atlanta, GA 30374-0815

You may also notify the *Secretary of the U.S. Department of Health and Human Services* of your complaint. We will not take any action against you for filing a complaint.

Financial Information Privacy Notice

We (including our affiliates listed at the bottom of this page)** are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your personal financial information.

**For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities on the first page of the Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group, Inc.; ACN Group IPA of New York, Inc.; Alliance Recovery Services, LLC; AmeriChoice Health Services, Inc.; Behavioral Health Administrators; Continental Plan Services, Inc.; Coordinated Vision Care, Inc.; DBP-KAI, Inc.; Disability Consulting Group, LLC; DCG Resource Options, LLC; Definity Health Corporation; Definity Health of New York, Inc.; Dental Benefit Providers, Inc.; Dental Insurance Company of America; Exante Bank, Inc.; Fidelity Benefit Administrators, Inc.; HealthAllies, Inc.; IBA Self Funded Group, Inc.; Illinois Pacific Dental, Inc.; Lifemark Corporation; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; Midwest Security Administrators, Inc.; Midwest Security Care, Inc.; National Benefit Resources, Inc.; NPD Dental Services; NPD Insurance Company, Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Pacific Dental Benefits; PacifiCare Behavioral Health NY IPA, Inc.; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.; Spectera of New York, IPA, Inc.; Uniprise, Inc.; United Behavioral Health of New York, I.P.A., Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Services, Inc.; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthcare Service LLC; United Medical Resources, Inc.*

Summary of State Laws on Use and Disclosure of Certain Types of Medical Information

This information is intended to provide an overview of state laws that are more stringent than the federal *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules* with respect to the use or disclosure of protected health information in the categories listed below.

Sexually Transmitted Diseases and Reproductive Health	
Disclosure of sexually transmitted diseases and reproductive health related information may be: (1) limited to specified circumstances; and/or (2) restricted by the patient.	HI, MS, NM, NY, NC, OK, WA, VA
Disclosure of sexually transmitted diseases and reproductive health information must be accompanied by a written statement meeting certain requirements.	NM
There are specific requirements that must be followed when an insurer uses or requests sexually transmitted disease tests or reproductive health information for insurance or underwriting purposes.	MS
Alcohol and Drug Abuse	
Disclosure of alcohol and drug abuse information may be: (1) limited to specified circumstances; (2) restricted by the patient; and/or (3) prohibited under certain circumstances.	GA, HI, KY, MA, NH, OK, VA, WA, WI
A specific written statement must accompany any alcohol and drug abuse information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests drug and alcohol tests or information for insurance or underwriting purposes.	KY, VA
Genetic Information	
An authorization is required for each disclosure of genetic information.	CA, HI, KY, LA, RI, TN
Genetic information may be disclosed only under specific circumstances.	AZ, CO, FL, GA, HI, IL, MD, MA, MO, NV, NH, NJ, NM, NY, OR, TX, VT
Restrictions apply to (1) the use; and/or (2) the retention of genetic information.	CO, GA, IL, NV, NJ, NM, OR, VT, WY
Specific requirements must be followed when an insurer uses or requests a genetic test for insurance or underwriting purposes.	FL, IL, IN, LA, NV, WY

HIV/AIDS	
Disclosure of HIV/AIDS related information may only be: (1) limited to specific circumstances; and/or (2) restricted by the patient.	AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KY, ME, MA, MI, NH, NJ, NM, NY, NC, OH, OK, OR, PA, TX, UT, VT, VA, WA, WV, WI
A specific written statement must accompany any HIV/AIDS related information.	AZ, CT, KY, NM, OR, PA, WV
Certain restrictions apply to the retention of HIV/AIDS related information.	MA, NH
Specific requirements must be followed when an insurer uses or requests an HIV/AIDS test for insurance or underwriting purposes.	AR, DE, FL, IA, MA, NH, PA, UT, VA, VT, WA, WV
Improper disclosure may be subject to penalties.	DE
Disclosure to the individual and/or designated physician may be required.	MA, NH
Mental Health	
Disclosure of mental health information may be: (1) limited to specific circumstances; (2) restricted by the patient; and/or (3) prohibited or prevented under certain circumstances.	AL, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, IA, KY, ME, MA, MD, MI, MN, NM, NY, OK, PA, TN, TX, VT, VA, WA, WV, WI
A specific written statement must accompany any mental health information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests mental health information for insurance or underwriting purposes.	IA, KY, ME, MA, NM, TN, VA
Child or Adult Abuse	
Abuse related information may only be disclosed under specific circumstances.	AL, LA, NM, TN, UT, VA, WI

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your enrolling group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the policy on the day before a qualifying event:

- A subscriber.
- A subscriber's enrolled dependent, including with respect to the subscriber's children, a child born to or placed for adoption with the subscriber during a period of continuation coverage under federal law.
- A subscriber's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

- A. Termination of the subscriber from employment with the enrolling group, for any reason other than gross misconduct.
- B. Reduction in the subscriber's hours of employment.

With respect to a subscriber's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

- A. Termination of the subscriber from employment with the enrolling group, for any reason other than the subscriber's gross misconduct.
- B. Reduction in the subscriber's hours of employment.
- C. Death of the subscriber.
- D. Divorce or legal separation of the subscriber.
- E. Loss of eligibility by an enrolled dependent who is a child.
- F. Entitlement of the subscriber to Medicare benefits.
- G. The enrolling group filing for bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired subscriber and his or her enrolled dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

Notification Requirements for Qualifying Event

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator within 60 days of the latest of the date of the following events:

- The subscriber's divorce or legal separation, or an enrolled dependent's loss of eligibility as an enrolled dependent.
- The date the Qualified Beneficiary would lose coverage under the policy.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The subscriber or other Qualified Beneficiary must also notify the enrolling group's plan administrator when a second qualifying event occurs, which may extend continuation coverage.

If the subscriber or other Qualified Beneficiary fails to notify the enrolling group's plan administrator of these events within the 60 day period, the plan administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a subscriber is continuing coverage under federal law, the subscriber must notify the enrolling group's plan administrator within 60 days of the birth or adoption of a child.

Notification Requirements for Disability Determination or Change in Disability Status

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A. below.

The notice requirements will be satisfied by providing written notice to the enrolling group's plan administrator. The contents of the notice must be such that the plan administrator is able to determine the covered employee and Qualified Beneficiary or beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the subscriber or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the enrolling group's plan administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the plan administrator.

The Qualified Beneficiary's initial premium due to the plan administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If you qualify or may qualify for assistance under the Trade Act of 1974, contact the enrolling group for additional information. You must contact the enrolling group promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that plan coverage was lost but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the policy will end on the earliest of the following dates:

- A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the subscriber's employment was terminated or hours were reduced (i.e., qualifying event A.).

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

- Notice of such disability must be provided within the latest of 60 days after:
 - the determination of the disability; or
 - the date of the qualifying event; or
 - the date the Qualified Beneficiary would lose coverage under the policy; and
 - in no event later than the end of the first eighteen months.
- The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.
- If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

- B. Thirty-six months from the date of the qualifying event for an enrolled dependent whose coverage ended because of the death of the subscriber, divorce or legal separation of the subscriber, or loss of eligibility by an enrolled dependent who is a child (i.e. qualifying events C., D., or E.).
- C. With respect to Qualified Beneficiaries, and to the extent that the subscriber was entitled to Medicare prior to the qualifying event:
- Eighteen months from the date of the subscriber's Medicare entitlement; or
 - Thirty-six months from the date of the subscriber's Medicare entitlement, if a second qualifying event (that was due to either the subscriber's termination of employment or the subscriber's work hours being reduced) occurs prior to the expiration of the eighteen months.
- D. With respect to Qualified Beneficiaries, and to the extent that the subscriber became entitled to Medicare subsequent to the qualifying event:

- Thirty-six months from the date of the subscriber's termination from employment or work hours being reduced (first qualifying event) if:
 - The subscriber's Medicare entitlement occurs within the eighteen month continuation period; and
 - If, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.
- E. The date coverage terminates under the policy for failure to make timely payment of the premium.
- F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
- G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the enrolling group filed for bankruptcy, (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the enrolling group filed for bankruptcy, (i.e. qualifying event G.) and the retired subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the subscriber's death.
- H. The date the entire policy ends.
- I. The date coverage would otherwise terminate under the policy.

