Vision Certificate of Insurance using a Preferred Provider Organization (PPO) Benefit Design
Effective on or after January 1, 2021 Plan Year

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

Welcome and General Information for Members

This document is your Certificate of Insurance ("Certificate"). Your Certificate establishes the terms of coverage for your vision plan. It sets forth which services are covered, and which services are not covered. It explains the procedures that you must follow to ensure that the vision services you receive will be covered under your vision plan. It also describes how you can add a dependent to your plan, submit a claim, file a Complaint, and other information that you may need to know to access your vision benefits. The Certificate acts as a contract between you and the Plan,* setting forth your obligations as a Member and our obligations as your vision benefits carrier. It is important to use this Certificate along with your Schedule of Benefits. Your Schedule of Benefits is the document that outlines your coverage amount and Benefit Limits. Anything contained herein to the contrary notwithstanding, the Plan shall have the right for the purpose of complying with the provisions of any law or any lawful order of a regulatory authority to amend, the Certificate or any attachment hereto or to increase, reduce, or eliminate any of the benefits provided for in the Certificate for any one or more eligible Members enrolled under the Certificate, and each party hereby agrees to any amendment of the Certificate which is necessary in order to accomplish such purpose.

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

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

This Is A Limited Policy—Read It Carefully

Diane P. Holder, President and CEO, UPMC Health Benefits Inc.

Scott Lammie, Chief Financial Officer, UPMC Health Benefits Inc

*UPMC Vision Care is a product of UPMC Health Benefits Inc. and administered by National Vision Administrators (NVA). References to the Health Plan or the Plan shall refer to UPMC Health Plan Inc. and UPMC Health Benefits Inc.

Health Care Concierge team

To help you get accurate answers to questions and up-to-date information about your vision program, please visit *My*Health OnLine via **www.upmchealthplan.com,** call 1-844-252-0687, or write to UPMC Vision Care, U.S. Steel Tower, 600 Grant Street, Pittsburgh, PA 15219. You can:

- Learn about UPMC Vision Care.
- Find network Participating Vision Providers.
- Verify eligibility for yourself and your dependents.
- Request an Out-of-Network Provider reimbursement form.
- Speak with our Health Care Concierge team via phone or online chat.
- Ask any questions about your vision care benefits.
- Initiate a Complaint of a benefit denial.

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

Helpful phone numbers

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

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Terms and Definitions to Help You Understand Your Coverage

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

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

Benefit Period – The period (for which you are eligible for coverage during your employer group/plan sponsor's contract year) during which charges for Covered Services must be incurred in order to be eligible for payment by the Plan. A charge is considered incurred on the date you receive the service or supply.

Complaint – A dispute or objection by a Member regarding a Participating Vision Provider or the coverage (including contract exclusions and non-covered benefits), operations, or management policies of this vision plan, which has been filed with the Plan but has not been resolved by the Plan. Instructions on how to file a Complaint are set forth in the Resolving Disputes with the Plan section of this Certificate.

Contract Holder – Person responsible for payment of premiums, or person whose employment is the basis for membership in a health plan.

Copayment – The specified dollar amount that you pay at the time of service for certain Covered Benefits. You are expected to pay your Copayment at the time of service. Refer to your Schedule of Benefits to determine Copayment amounts.

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

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

Extended Wear (Planned Replacement/Frequent Replacement) Contact Lenses – Contact lenses that may be utilized for a specified period of time, i.e. daily, 1 week, 2 weeks, etc. at which time they are discarded. In most cases they are removed, cleaned and sterilized following wear. In some cases they may be worn while sleeping, if approved by an eye care professional. Wearing schedules and duration of use must be as prescribed.

Maximum Allowable Charge – The maximum amount the Plan will allow for a Covered Service.

Member – An individual or dependent who is enrolled in and covered by this Certificate.

Medical Necessity or Medically Necessary – Health care services covered under your Vision plan that are determined by UPMC Vision Care to be:

- Commonly recognized throughout the provider's specialty as appropriate for the diagnosis and/or treatment of the Member's condition, illness, disease, or injury.
- Provided in accordance with standards of good medical practice and consistent with scientifically based guidelines of medical, research, or health care coverage organizations or governmental agencies that are accepted by UPMC Vision Care.

- Reasonably expected to improve an individual's condition or level of functioning and in conformity time of treatment with medical management criteria/guidelines adopted by UPMC Vision Care or its designee.
- Provided not only as a convenience or comfort measure or to improve physical appearance.
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service.

UPMC Vision Care reserves the right to determine whether a health care service meets these criteria. Approval for coverage based upon Medical Necessity shall be made by UPMC Vision Care, at its discretion, with input from the treating provider. Note that the fact that a provider orders, prescribes, recommends, or approves a health care service does not mean that the service is Medically Necessary or a Covered Benefit for purposes of coverage.

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

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

Nonparticipating Vision Provider – A vision provider who is not a contracted provider with National Vision Administrators.

Participating Vision Laboratory – An optical laboratory who has entered into an agreement with the Plan to render Covered Services to UPMC Vision Care Members through an arrangement with National Vision Administrators.

Participating Vision Provider – A vision provider who has entered into an agreement with the Plan to render Covered Services to UPMC Vision Care Members through an arrangement with National Vision Administrators. A Participating Vision Provider may also include Participating Vision Providers who use a Nonparticipating Vision Laboratory.

Payment of Benefits – After UPMC Vision Care determines the Maximum Allowable Charge for Covered Services provided to the insured by a particular type of provider, UPMC Vision Care applies all of the insured's Copayment amounts to the Maximum Allowable Charge to determine the benefit amount payable by UPMC Vision Care.

Prior Authorization – A formal process requiring a Participating Vision Provider to obtain approval to provide particular services or procedures before they are done. This is usually required for nonemergency services that are expensive or likely to be abused or overused. NVA will identify those services and procedures that require Prior Authorization. Without prior authorization these services may not be covered by the Plan

Proof of Loss – Documentation to support a claim.

Schedule of Benefits – A document that lists Covered Services, Copayments and Benefit Limits.

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

Specialty Contact Lenses – Lenses that require additional professional time in fitting and follow up care. These include Rigid Gas (O2) Permeable lenses, Toric (correct for astigmatism) lenses and Multi-focal lenses.

Usual, Customary, and Reasonable (UCR) – For the services authorized by UPMC Vision Care that are provided by a Non-Participating Vision Provider, the UCR charge is the amount that UPMC Vision Care determines is reasonable for Covered Services pursuant to industry standards. The Nonparticipating Provider may charge you the difference between the billed amount and the UCR amount.

Eligibility and Enrollment – When Coverage Begins

When will your coverage begin?
Your coverage will begin on the effective date communicated to you by your employer or plan sponsor. Note that some employer or plan sponsors set minimum waiting periods before your coverage will be effective.

Who is eligible for coverage?
You are eligible for coverage if you are an employee of the employer/plan sponsor and you meet any additional eligibility criteria established by your employer and/or the Plan. Other than yourself, you may enroll the following individuals as dependents:

- Your spouse under a legally valid existing marriage[1].
- Children under 26 years of age, including newborn children, stepchildren, children legally placed for adoption, and children for whom coverage is mandated by a Qualified Medical Child Support Order are eligible for coverage under the terms of this Certificate, except as provided in an Eligibility Rider.
- For Affordable Care Act (ACA) compliant plans, children up to age 19 may be covered for pediatric vision Essential Health Benefits (EHB) under their medical policy. For more information, please refer to your medical plan documents.
- Disabled dependents who meet the criteria set forth in the section titled "Disabled Dependents", located in the "How do you enroll a dependent?" section.

To obtain coverage for a dependent, you may be required by your employer, plan sponsor, and/or the Plan to provide proof that the individual meets criteria for one of the above eligibility categories.

How do you enroll a dependent?
There are two ways you can enroll an eligible dependent. First, you may enroll an eligible dependent during your open enrollment period. Second, you may enroll an eligible dependent within 31 days[2] of the date on which the dependent becomes eligible for coverage. You must complete and submit an enrollment application to your employer or plan sponsor within the 31-day period. The following are rules for special circumstances regarding coverage of dependents.

Newborn children: Newborn children are covered automatically from the moment of birth for 31 days. To obtain coverage for that child beyond the initial 31-day period, you must contact your employer or plan sponsor to enroll the child as a dependent before the end of the initial 31-day coverage period. If you do not contact your employer or plan sponsor, coverage for that child will end after the 31-day automatic coverage period.

Adopted children: Adopted children are covered automatically from the date of legal placement for 31 days. To obtain coverage for that child beyond the initial 31-day period, you must contact your employer or plan sponsor to enroll the child as a dependent before the end of the 31-day coverage period. If you do not contact your employer or plan sponsor, coverage for that child will end after the 31-day automatic coverage period.

Qualified Medical Child Support Orders (QMCSO): A medical child support order is a judgment, decree, or order made by a court of competent jurisdiction or an authorized state administrative agency that is made under state domestic relations law or state laws relating to medical child support. The order provides for medical support or health benefit coverage for a child of a Member under a group health plan. A QMCSO is a medical child support order that contains at least the following information: (1) the name and last known mailing address of the Member and each child to be covered under the QMCSO[3]; a reasonable description of the type of health coverage to be provided to each child, or the manner in which such coverage is to be determined;

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[1] Some Employers offer coverage domestic partners of the same and/or the opposite sex. This is called Domestic Partner coverage and if offered is included in your medical plan documents.
[2] Days in the Certificate refers to calendar days unless stated as business days.
[3] The order may substitute the name and making address of a state or local official for a child's mailing address.

and (3) the period of time to which the QMCSO applies. Your employer or plan sponsor may determine whether a medical support order is a QMCSO. For more information regarding QMCSOs, contact your employer or plan sponsor.

Disabled dependents: The disabled dependent child, as medically certified by a physician due to intellectual or physical disability, mental illness, or developmental disability, who became so prior to the attainment of age nineteen (19) must:

- Be unmarried and remain unmarried while enrolled in UPMC Vision Care; and
- Be incapable of self-sustaining employment; and
- Be chiefly dependent upon you for support and maintenance; and
- Be your child (either from birth, as a stepchild, or through legal adoption) or a child for whom the Member is legally obligated to provide principal support through a QMCSO.

In order to continue coverage for your disabled dependent after the attainment of age 19, you must submit proof of such dependent's incapacity by contacting Member Services within thirty-one days of the dependent's attainment of the limiting age.

Remember that, for UPMC Vision Care to properly manage your benefits and coverage, you must keep your employer or plan sponsor up to date regarding any changes in your contact information (address, telephone number, etc.).

Loss of other vision coverage: You may enroll yourself or a dependent for whom you previously declined coverage because you or your dependent had vision benefits, within 31 days of the loss of such coverage, if:

- When you declined the coverage, you stated in writing that you did so because you or the dependent had other vision coverage; OR
- When you declined the coverage, you or the dependent had COBRA coverage and that coverage has since been exhausted; OR
- When you declined the coverage, you or your dependent had Medical Assistance or Children's Health Insurance Program (CHIP).
    - Notwithstanding the 31-day enrollment period set forth in the subsection above, if you or your dependent(s): (1) are covered under Medical Assistance or CHIP but lose eligibility for that coverage; OR (2) become eligible for a premium assistance subsidy under Medical Assistance or CHIP, you or your dependent(s) will have 60 calendar days to enroll in coverage under this Plan.

The termination of the prior coverage must have occurred due to your or the dependent's loss of eligibility for such coverage or the termination of an employer or plan sponsor's contribution toward the premium for the coverage. To be eligible for this special enrollment period, prior coverage from the Plan must not have been terminated because of your or your dependent's failure to make timely premium payments or for cause (for example, making a fraudulent claim).

Enrolling or changing enrollment status

You may apply for enrollment or change the enrollment status for yourself or a dependent during open enrollment or within 31 days of an individual becoming eligible for coverage. To apply for enrollment or change enrollment status, complete and submit an enrollment form to your employer or plan sponsor. Remember that, for the Plan to properly manage your benefits and coverage, you must keep your employer or plan sponsor up to date regarding any changes in your contact information (address, telephone number, etc.) and changes in your family status (marriages, deaths, births, etc.).

The restriction on enrolling new dependents only during open enrollments when the Member fails to enroll them within 31 days of a life-changing event does not apply to dependent children of a Member subject to a court or administrative order of support relating to the provision of health care coverage.

What happens to your coverage when you are on leave or are laid off?
When you are on a leave of absence or are laid off, your employer or plan sponsor may choose to continue your coverage. If so, your coverage will continue as long as the Plan receives the required premium from your employer or plan sponsor. Also, if your employer or plan sponsor does not continue coverage during a period of leave of absence or layoff, your employer or plan sponsor may allow you to resume coverage upon returning to work. Contact your employer or plan sponsor for more information.

Military leave
If an eligible dependent child who is a member of the Pennsylvania National Guard or any reserve component of the United States Armed Forces and a full-time student at a school, college, or university has been called to active duty (other than active duty for training) for a period of 30 or more consecutive days, that dependent is eligible for an extension of coverage for a period equal to the duration of active duty service or until the dependent is no longer a full-time student. Eligibility of a dependent called to active duty may not be terminated by reason of age when his or her enrollment was interrupted because of such military duty.

For purposes of this section, a "full-time student" is defined as a student enrolled in an approved institution of higher learning pursuing an approved program of education equal to or greater than 15 credit hours or its equivalent recognized by the Pennsylvania Higher Education Assistance Agency as a full-time course of study.

To qualify for the active duty extension, the dependent must (1) submit a form approved by the Department of Military and Veterans Affairs notifying the Plan that the dependent has been placed on active duty; (2) submit a form approved by the Department of Military and Veterans Affairs notifying the Plan that the dependent is no longer on active duty; and (3) submit a form approved by the Department of Military and Veterans Affairs showing that the student has re-enrolled as a full-time student, as set forth above, for the first term or semester starting 60 or more days after his or her release from active duty.

Court order
Coverage for dependents who are covered under a court order or other legally binding instrument documenting custody or guardianship of a minor will be effective no later than 30 days from UPMC Health Plan's receipt of the documentation provided that the dependent has submitted a completed application, the application has been accepted by UPMC Health Plan, and appropriate premium payment has been made.

If UPMC Health Plan has been made aware that a dependent has been enrolled pursuant to a court order, UPMC Health Plan will not disenroll or eliminate coverage of such dependent unless it is provided with evidence that the court order is no longer in effect or the dependent will be enrolled in comparable health coverage through another insurer.

Medically Necessary leave of absence
If your coverage under this Certificate of Insurance is based on your status as a student enrolled at a postsecondary educational institution, your coverage may be continued during a Medically Necessary leave of absence, subject to certification by your treating physician and certain limitations as set forth in applicable law.

How the Vision Plan Works

Choosing a vision provider

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

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

To find a Participating Vision Provider, log in to *My*Health OnLine at **www.upmchealthplan.com** or call our Health Care Concierge team at [-844-252-0687**.** When you visit the vision provider's office, let your vision provider know that you are covered under UPMC Vision Care and provide them with your ID card. If you do not have an ID card, you can download one from *My*Health OnLine. An ID card is not required for treatment. If your vision provider has questions about your eligibility or benefits, instruct the office to call 1-877-262-7870 or visit **www.upmchealthplan.com/providers.** The provider may use demographic information, such as name and date of birth, to verify eligibility and submit claims.

Relationship with vision providers
The relationship between the Plan and vision providers is that of independent contractors, and neither the Plan nor any vision provider shall be considered an agent or representative of the other for any purpose.

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

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

The Plan does not provide or render Covered Services, but only makes payment or provides coverage for Covered Services that you receive. Vision providers are solely responsible for any vision services rendered to you. The Plan is not liable for any act or omission of any vision provider who renders vision services to you. The Plan has no responsibility for a vision provider's failure or refusal to render vision services to you.

Out-of-network services
UPMC Vision Care encourages its Members to use Participating Vision Providers to maximize their benefit and minimize any out-of-pocket expenses. Participating Vision Providers can be located by visiting **www.upmchealthplan.com.** Please select the appropriate network, **Coverage Through My Employer**, **UPMC Vision Care**, to locate a participating provider.

If you elect to have services performed by a Nonparticipating Vision Provider, UPMC Vision Care will reimburse you for eligible services up to the benefit maximum. You may download an out-of-network reimbursement form from our website at **www.upmchealthplan.com** or call our Health Care Concierge team at 1-844-252-0687 to have a form sent to you.

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

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

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

Benefits

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

Any Affordable Care Act (ACA) requirements involving medical benefits will be included in your medical Certificate of Coverage or other plan documents. For example, Members to the age nineteen (19) who are enrolled in an ACA-compliant medical plan are entitled to pediatric vision services under that medical plan. Find eligibility and benefit details in your medical plan documents or by calling your medical carrier.

Services

The general descriptions below explain the services set forth on the Schedule of Benefits. The descriptions are *not* all-inclusive – they include only the most common vision procedures in a class or service grouping. Specific vision procedures may not be covered depending on your employer's or plan sponsor's choice of plan. Check the Schedule of Benefits to see what services are covered. Also, have your vision provider call UPMC Vision Care to verify coverage of specific vision procedures or log in to *My*Health OnLine at **www.upmchealthplan.com** to check coverage. Services covered on the Schedule of Benefits are also subject to exclusions. Be sure to review the Schedule of Exclusions within this Certificate.

- **Vision Examination** – routine vision exams including refraction
  - New patient
  - Established patient
- **Lenses** – per lens
  - Single vision
  - Bifocal
  - Trifocal
  - Progressive lenses (refer to your plan documents). Coverage for progressive lens may vary based on the type of progressive lens prescribed and is in addition to lens (single & bifocal) reimbursement.
- **Frames**
  - Plan allowance is based on retail value**. (Refer to your employer plan documents for your plan allowance.)**
- **Elective Contact Lenses** – in lieu of frames and lenses for eyeglasses
  - A separate allowance for the fitting fee (Standard or specialty. For specialty exams, the provider may balance bill the Member the difference between the plan's reimbursement and their charges.)
  - Lens and materials (Daily Wear, Extended Wear, or Specialty)
  - Medically Necessary contact lenses reimbursement is based on Usual, Customary, and Reasonable (UCR) as determined by UPMC Vision Care. Prior Authorization from NVA is required. The provider may balance bill the Member for the difference between the billed amount and the amount paid by the plan.

UPMC Vision Care provides coverage for Additional Lens Options, such as coatings, tinting, polarization, photochromatics, and other lens add-ons. A Copayment may apply for these additional services. Refer to your employer specific Schedule of Benefits and Additional Lens Options document for plan specific information.

UPMC Vision Care also offers Members an additional discount benefit through the NVAEYEESSENTIAL® Plan. After eligible Members have exhausted their funded benefit they are eligible to access the NVA EYEESSENTIAL® Plan discount on additional purchases during the plan period Refer to your plan documents for discounts on exams, lenses for eyeglasses, frames, and contact lenses. If Members choose additional options not specified in their plan documents, they are responsible for the additional cost of the options to be paid to the provider directly. Not all providers participate in the discount plan. To locate a participating NVA EYEESSENTIAL Vision provider, visit our website at www.upmchealthplan.com]or call the Health Care Concierge team at 1-844-252-0687 for assistance.

Replacement Eyeglass Policy

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

Replacement and repair policy may not apply or vary when receiving services from a Nonparticipating Vision Laboratory. Please consult with your vision provider regarding their replacement/repair policy.

UPMC Vision Care Policy on Non-Adapts For Members with Progressive Addition Lenses (PALs) and Digital Single Vision Lenses.

On occasion, Members receiving Progressive Addition Lenses, or certain types of Digital Single Vision Lenses, experience difficulty in adapting to this new lens technology, even though the prescription is correct and the Member is properly fitted. The vision industry considers this to be a "Non- Adapt" situation for which the UPMC Vision Care Program provides protection in the form of the following warranty.

Any Member who is unable to adapt to a PAL or Digital Single Vision Lens will be offered a replacement pair of conventional Single Vision, Bifocal or Trifocal lenses, into the same frame at no charge. The replacement lenses must be the same material and prescription as the original lenses and will include, at no additional charge, any lens options for which you previously paid a fee. Please note that any amount you paid for the original lenses is not refundable, so be sure that you discuss your visual needs and likelihood of success in wearing these lenses with your provider before placing your order. This replacements policy is valid for up to 90 days from the receipt of your eyeglasses and may not apply when a Nonparticipating Vision Laboratory is used.

Schedule of Benefits

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

- The classes of vision services covered, shown with the Maximum Allowable Charge that the Plan pays for those services.
- Any Member out-of-pocket costs or cost-sharing for a Covered Service.
- Any Copayments you and/or dependents must pay per benefit or Benefit Period before any Covered Services will be paid by the Plan.
- Any limits for Covered Services for a given period of time, for example, annual limitations on lenses. Annual limits are applied on a Benefit Period basis.

Your out-of-pocket costs

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

Exclusions

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

Claims

Claims submissions

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

To obtain a Nonparticipating Vision Provider form, go to *My*Health OnLine or contact Member Services at 1−844-252-0687. Be sure to include on the claim form:

- Member's name
- Member's date of birth
- Subscriber's Social Security number
- Subscriber's name and address
- The name and policy number of a second insurer if the Member is covered by another vision plan
- Proof of payment (if no proof of payment, the Member will need to include detailed information regarding the service – vision provider name, address, date of service, and amount charged)

Claim forms should be sent to:

UPMC Vision Care
PO Box 106039
Pittsburgh, PA 15230-6039

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

Notice of claim

The Plan will not be liable under this Certificate unless proper notice is furnished to the Plan that Covered Services in this Certificate have been rendered to a Member. Written notice must be given to the Plan within twenty (20) days following the date in which the Covered Services were rendered or as soon as reasonably possible thereafter. The Member must give notice to the Plan in writing. The notice must include the data necessary for the Plan to determine benefits, such as date of service, services rendered, provider name, office location, charges, etc. A charge shall be considered incurred on the date the Member receives the service or supply for which the charge is made.

Claim forms

Proof of Loss for benefits under this Certificate must be submitted to the Plan on the appropriate claim form. The Plan, within 15 days following the date the notice of a claim is received, will furnish claim forms to the Member for filing Proof of Loss. If such forms are not furnished withing fifteen days after giving of such notice, the claimant shall be deemed to have complied with the requirements of this Certificate as to the filing a Proof of Loss upon submitting, within the time fixed in this subsection for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of loss

Written Proof of Loss must be furnished to the Plan within 90 days after the date of such loss. Failure to give notice to the Plan within the time required will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no case, except in the absence of legal capacity, will the Plan be required to accept notice later than one year after the end date in which the Covered Service was rendered.

Timely payment of claims

Subject to due written Proof of Loss, all claims payable under this Certificate will be paid immediately, according to any applicable regulatory requirements. For submitted claims, the Plan will not be liable under this Certificate unless proper notice is furnished to the Plan that Covered Services have been rendered to a Member. Claims must be submitted to the plan within a year from the date of service.

Payment of Benefits

If you have treatment performed by a Participating Vision Provider, we will pay Covered Benefits directly to the Participating Vision Provider. Payment will be based on the Maximum Allowable Fee Charge that the treating Participating Vision Provider has contracted to accept and what your benefit allows.

If you receive treatment from a Nonparticipating Vision Provider, we will send payment for Covered Benefits to you unless otherwise indicated on the claim form. The Plan payment will be based on the Maximum Allowable Charge for the services. You will be responsible to pay the vision provider any difference between the Plan's payment and the vision provider's full charge for the service. A Member's right to reimbursement for any Covered Service is not assignable.

Overpayments

If we make an overpayment for benefits, we have the right to recover the overpayment. In the event that overpayment was made to the Member, we will recover the overpayment by requesting a refund. Recovery will be done in accordance with any applicable state laws or regulations

Coordination of Benefits

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

- When your other coverage does not mention "coordination of benefits," then that coverage pays first. Benefits paid or payable by that coverage will be taken into account when we determine if additional benefit payments can be made under this Plan.
- When you are covered as an employee under one plan and as a dependent under another, the employee coverage pays first.
- When the dependent child is covered under two plans, the plan covering the parent whose birthday occurs earlier in the calendar year pays first. If both parents have the same birthday, then the plan under which one parent was covered longest pays first.
- If the dependent child's parents are separated or divorced and:
  - The parent with custody of the child has not remarried; the coverage of the parent with custody pays first.
  - The parent with custody has remarried, the coverage of the parent with custody pays first, but the stepparent's coverage, if any, pays before the coverage of the parent without custody.
  - There is a court order that specifies the parent who is financially responsible for the child's vision expenses, the coverage of that parent pays first.
- If the service is also covered under the medical plan in which the Member may be enrolled in, the medical plan pays first. If it is a covered vision benefit, vision coverage will be considered the secondary payer.

- When none of the above circumstances applies, the coverage that you have had the longest applies first, as long as:
    - The benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person; and
    - The other plan does not have a provision regarding laid-off or retired employees and, therefore, the benefits of each plan are determined after the other, then the provisions listed above shall not apply.

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

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

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

UPMC Vision Care is not required to determine whether or not you have other vision benefits or insurance or the amount of benefits payable under any other vision benefits or insurance. The Plan shall only be responsible for coordination of benefits to the extent that information regarding your other insurance is provided to the Plan by you, your employer or plan sponsor, another insurance company, or any other entity or person authorized to provide such information.

Workers' Compensation

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

Review of a benefit determination

If you are not satisfied with your benefits under the Plan, please contact us at 1-844-252-0687. If, after speaking with our Health Care Concierge team, you are still dissatisfied, refer to the **"Resolving Disputes with the Plan"** subsection of this Certificate for further steps you can take regarding your claim.

Resolving Disputes with the Plan

At times, you may not be satisfied with a decision that the Plan makes regarding your coverage or with the vision services you have received. As a Member of UPMC Vision Care, you have the right to file a Complaint.

The Complaint process

A Member with a Complaint about a Participating Vision Provider, coverage, operations, or the Plan's management policies should contact our Health Care Concierge team at 1-844-252-0687. TTY users should call 711.

The Member may appoint in writing a representative to act on his or her behalf. In addition, the Member or the Member's representative may request the help of a Plan employee who has not taken part in the decision to deny coverage or the issue in dispute. That employee will assist the Member in preparing the Complaint at no charge to the Member. Complaints must be filed with UPMC Vision Care within 180 days from denial notification or of the occurrence.

There is one step in the internal Complaint process — the initial review, which is described in this section.

Initial review

1. **Member files a Complaint.**
   Complaints may be verbal or in writing and may include documentation. The Complaint should indicate the remedy or corrective action being sought. For example, a Complaint may deal with a claim denial, and the remedy being sought is payment of the claim. All written Complaints should be submitted to:

   UPMC Vision Care
   Member Complaints
   PO Box 2939
   Pittsburgh, PA 15230-2939

   Verbal Complaints can be made to our Health Care Concierge team by calling 1-844-252-0687.
   TTY users should call 711.

2. **UPMC Vision Care acknowledges the Complaint.**
   The Plan sends a letter to the Member within five business days stating that it has received the Complaint.

3. **The Initial Complaint Review Committee investigates the Complaint**.
   The committee, which consists of one or more Plan employees, investigates the Complaint.

4. **The committee makes a decision and notifies the Member.**
   The committee makes a decision within 30 calendar days of receiving a Complaint. The committee notifies the Member in writing within five business days of making its decision, giving its reasons and the Member's appeal rights, if applicable.

If the Member accepts the decision of the Initial Complaint Review Committee, no further action is required. However, if the Member wishes to appeal this decision AND the employer or plan sponsor provides health benefits to the Member through an employer-sponsored group plan subject to ERISA, the Member may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). The Member should contact his or her employer or plan sponsors to obtain additional information concerning his or her rights under ERISA.

Termination – When Coverage Ends

There are many reasons for which your coverage with UPMC Vision Care may terminate. Some of those reasons are:

- You are deceased
- You are no longer an employee.
- Non-payment of premium to the Plan.
- Your employer or plan sponsor no longer contracts for coverage with UPMC Vision Care. If your employer or plan sponsor decides to terminate its contract with us, it is the employer or plan sponsor's responsibility to tell you that your coverage will terminate.
- UPMC Vision Care reasonably establishes that you have committed fraud or made a material misrepresentation in information submitted to the Plan or in obtaining or using services under this Certificate. This includes improper use of your vision coverage, such as allowing another person to use your coverage to obtain vision services.

Federal law may require certain employers or plan sponsors to offer continuation coverage to Members for a specified period of time upon termination of employment or reduction of work hours for any reason other than gross misconduct. You should contact your employer or plan sponsor to find out whether or not this requirement applies to you and your employer. Your employer or plan sponsor will advise you of your rights to continuation coverage and the cost. You may elect to extend dependent's(s') coverage, or the dependent(s) may elect to continue coverage under certain circumstances or qualifying events. You must pay the required premium for continuation coverage directly to your employer or plan sponsor. The Plan is not responsible for determining who is eligible for continuation coverage.

Grace period
A grace period of 31 days from the due date will be granted for payment of the required premium. During the grace period, the Certificate will remain in force.

Reinstatement
If your coverage under this Certificate has been terminated for failure to pay premiums, UPMC Vision Care will reinstate your coverage as long as your premium due is paid in full within 31 calendar days after the end of the grace period. In all other aspects the insured and insurer shall have the same rights thereunder as they had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

Schedule of Exclusions

What is not covered

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

- Any additional service required outside of basic vision analysis for contact lenses, including but not limited to fitting fees, unless otherwise specified in the Schedule of Benefits.
- **Blood**: Non-purchased blood or blood products, including autologous donations.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan.
- **Cosmetic Surgery**: Surgical or other services performed solely for cosmetic reasons ─ to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons and from which no improvement in physiological function can be expected.
- **Court-ordered services**: Court-ordered services when your vision provider or other professional provider determines that those services are not appropriate.
- **Employment-related or employer-sponsored services**:
  - A. For any illness or bodily injury that occurs in the course of employment, if benefits or compensation is available in whole or in part, pursuant to any federal, state, or local government's workers' compensation, or occupational disease, or similar type of legislation. This exclusion applies whether or not you claim those benefits or compensation.
  - B. Services that you receive from a vision or medical department, operated in whole or in part by, or on behalf of, an employer, mutual benefit association, labor union, trust, or similar entity.
- **Experimental/Investigational**: Services that are Experimental/Investigational in nature as determined by the Plan.
- **Medical/vision services not identified as "covered" in this Certificate**: Any other medical or vision service or treatment, except as provided in this Certificate or as mandated by law.
- **Medicare**: Services for which or to the extent that payment has been made pursuant to Medicare coverage, when Medicare coverage is primary; however, this exclusion does not apply when your employer or group plan sponsor is required to offer you all of the benefits set forth in this Certificate by law and you elect this coverage as your primary coverage.
- **Military service**:
  - A. Care for military service-connected disabilities and conditions for which you are legally entitled to services and for which facilities are reasonably accessible to you.
  - B. Services that are provided to members of the armed forces and the National Health Service or to individuals in Veterans Administration facilities for military service- related illness or injury, unless you have a legal obligation to pay.
- **Miscellaneous:** Any services, supplies, or treatments not specifically listed in the Certificate as Covered Benefits, services, supplies, or treatments, unless they are a basic vision service.
  - A. Services provided by a non-licensed practitioner.
  - B. Services incurred after the date of termination of your coverage, except as provided elsewhere in this Certificate.
  - C. Services rendered prior to the effective date of your coverage.
  - D. Services for which you otherwise would have no legal obligation to pay.
  - E. Charges for telephone consultations unless otherwise allowed in accordance with Plan policy.
  - F. Charges for failure to keep a scheduled appointment.

G. Services performed by a vision provider enrolled in an education or training program when such services are related to the education or training program.

H. Charges for completion of any insurance form or copying of vision or medical records.

I. Services that are submitted by two different vision providers for the same services performed on the same date for the same individual.

J. Services for, or related to, any illness or injury suffered after the effective date of your coverage that is the result of any act of war.

K. Services that are more than the Maximum Allowable Charge.

L. Expenses incurred by you or any one of your dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. The Plan will take into account any adjustment option chosen under such part by you or any one of your dependents.

M. Replacement of lost, broken, or stolen eyewear (glasses or contact lenses), unless otherwise stated in plan documents. NVA network providers may offer additional warranties to cover materials unless otherwise stated in plan documents.

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

General Provisions

This Certificate, together with any schedules attached hereto and incorporated by reference, represents the entire agreement between the parties with respect to the subject matter. The failure of any section or subsection of this Certificate shall not affect the validity, legality, and enforceability of the remaining sections.

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

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

The pertinent laws and regulations for interpretation and enforcement of this Certificate are the laws and regulations of the Commonwealth of Pennsylvania.

Entire contract; changes

Subject to the contract between your employer and UPMC Health Plan, this Certificate of Insurance, including the schedules, riders, and other documents attached hereto and issued in accordance herewith, represents the entire contract of insurance between you and UPMC Health Plan. No agent or representative of UPMC Health Plan other than a Health Plan officer may otherwise change this Certificate of insurance or waive any of its provisions. All statements you made will, in the absence of fraud, be deemed representations, and not warranties, and no such statement will be in defense to a claim under this Certificate of Insurance, unless it is contained in a written instrument signed by and furnished to you.

Physical examinations

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

Legal actions

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

Time limit on certain defenses

After three (3) years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Certificate shall be used to void the Certificate or to deny a claim for loss incurred or disability (as defined in this policy) commencing after the expiration of such three (3) year period.

Misstatement of age

If your age has been misstated, all amounts payable under the plan shall be the premium amount owed if The Plan had been purchased at the correct age. The Plan shall notify you of the correct premium amount on immediately following its discovery of the error. The correct premium amount shall also be applied retroactively, which may result in you owing additional premium amounts as of the Effective Date of your Certificate.

Fraud and abuse

According to Pennsylvania statute:

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

The Plan is committed to ensuring the integrity of, provision of, and payment for Covered Services necessary for vision care to our Members. In the event that you suspect that a UPMC Vision Care Member or a vision provider is committing fraud or abuse, contact our Special Investigations Unit at **1-866- FRAUD01** (1-866-372-8301) or specialinvestigationsunit@upmc.edu.

This Is A Limited Policy—Read It Carefully

UPMC HEALTH PLAN

U.S. Steel Tower, 600 Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com

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Nondiscrimination notice

UPMC Health Plan, on behalf of itself and its affiliates, complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation.

UPMC Health Plan provides free aids and services to people with disabilities so that they can communicate effectively with us. Aids and services may include:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

UPMC Health Plan provides free language services to people whose primary language is not English. Language services may include:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact the Member Services phone number listed on the back of your member ID card.

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

Complaints and Grievances
PO Box 2939
Pittsburgh, PA 15230-2939

Phone: 1-888-876-2756 (TTY: 711)
Fax: 1-412-454-7920
Email: HealthPlanCompliance@upmc.edu

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019. TTY/TDD users should call 1-800-537-7697.

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

Translation services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-869-7228 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-869-7228（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-869-7228 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-869-7228 (телетайп: 711).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-869-7228 (TTY: 711).

주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-855-869-7228 (TTY: 711) 번으로 전화해 주십시오 .

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-869-7228 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-869-7228 (رقم هاتف الصم والبكم: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-869-7228 (ATS: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-869-7228 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-869-7228 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-869-7228 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-869-7228 (TTY: 711).

សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ យើងមានផ្តល់សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខ 1-855-869-7228 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-869-7228 (TTY: 711).