Pediatric Vision Care Services
Offered by UnitedHealthcare of California
Supplement to the Combined Evidence of Coverage and Disclosure Form (HMO)
January 1, 2014
This Supplement to the Group Services Agreement is issued to the Employer Group and provides Benefits for Vision Care Services, as described below, for Members under the age of 19. Benefits under this Supplement terminate on the date the Member reaches the age of 19.

Because this Supplement is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the Evidence of Coverage and Disclosure Form in Section 10: DEFINITIONS or in this Supplement in Section 3: Defined Terms for Pediatric Vision Care Services.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare of California. When we use the words "you" and "your" we are referring to people who are Covered Members, as the term is defined in the Evidence of Coverage in Section 10: DEFINITIONS.
Section 1: Covered Services for Pediatric Vision Care Services

Covered Services are available for pediatric Vision Care Services from a Spectera Eyecare Networks Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

Benefits are not available for Vision Care Services that are not provided by a Spectera Eyecare Networks Vision Care Provider.

When obtaining these Vision Care Services from a Spectera Eyecare Networks Vision Care Provider, you will be required to pay any Copayments at the time of service.

Schedule of Benefits

<table>
<thead>
<tr>
<th>Vision Care Service</th>
<th>Frequency of Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Vision Examination or Refraction only in lieu of a complete exam.</td>
<td>Once per year.</td>
<td>Covered in full</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision Care Service</th>
<th>Frequency of Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyeglass Lenses - one pair</td>
<td>Once per year.</td>
<td>10%</td>
</tr>
<tr>
<td>▪ Single Vision</td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td>▪ Bifocal</td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td>▪ Trifocal</td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td>▪ Lenticular</td>
<td></td>
<td>10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision Care Service</th>
<th>Frequency of Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyeglass Frames</td>
<td>Once per year.</td>
<td>10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision Care Service</th>
<th>Frequency of Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Contact Lens Selection in lieu of eyeglasses</td>
<td>Limited to a one year supply.</td>
<td>10%</td>
</tr>
<tr>
<td>Necessary Contact Lenses</td>
<td>Limited to a one every year supply.</td>
<td>10%</td>
</tr>
</tbody>
</table>

Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Out-of-Pocket Maximum - Any amount you pay in Copayments for Vision Care Services under this Supplement applies to the Out-of-Pocket Maximum stated in the Schedule of Benefits.
Benefit Description

Benefits
Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits
Covered Services are provided for the Vision Care Services described below, subject to Frequency of Service limits and Copayments stated under each Vision Care Service in the Schedule of Benefits below.

Routine Vision Examination
A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.
- Dilation, if professionally indicated.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Low Vision Service
The low vision benefit is available to you if have severe visual problems that cannot be corrected with regular lenses. This benefit is available where a Vision Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Provider and not by us.

This benefit includes:

- Low Vision Testing: Complete low vision analysis and diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low Vision Therapy: Subsequent low vision therapy if prescribed.
- The frequency of your testing and therapy will be increased when one of the following occurs:
- A .50 diopter or more change in prescription.
- A shift in axis of astigmatism of five percent (5%) or more.
- A difference in vertical prism greater than one prism diopter.
- Replacement of lenses and/or frames due to them being lost or stolen.
- You have diabetes or hypertension.

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

You 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 Vision Care Services, we will pay benefits for only one Vision Care Service.

Lenses include choice of glass or plastic lenses, all lens powers.

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

**Eyeglass Frames**
A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to select only one of either eyeglasses or *Contact Lenses*. Eyeglasses consist of either eyeglass lenses or both eyeglass lenses and frames. If you select more than one of these Vision Care Services, we will pay benefits for only one Vision Care Service.

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

Covered Services include the fitting/evaluation fees and contacts.

You 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 Vision Care Services, we will pay benefits for only one Vision Care Service.

**Necessary Contact Lenses**
Covered Services are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:
- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological Myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic Disorders.
Section 2: Pediatric Vision Exclusions

Except as may be specifically provided in this Supplement under Section 1: Covered Services for Pediatric Vision Care Services, Covered Services are not provided under this Supplement for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Covered Services are available as stated in the Combined Evidence of Coverage and Disclosure Form.
2. Vision Care Services received from a non-Spectera Eyecare Networks Vision Care Provider.
3. Non-prescription items (e.g. Plano lenses).
4. Replacement or repair of lenses and/or frames that have been lost or broken.
5. Optional Lens Extras not listed in Section 1: Covered Services for Vision Care Services.
7. Applicable sales tax charged on Vision Care Services.

Section 3: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in Section 10: DEFINITIONS of the Combined Evidence of Coverage and Disclosure Form:

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

Spectera Eyecare - the provider network through which your access to Vision Care Providers is arranged.

Vision Care Provider - any participating optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services

Vision Care Service - any service or item listed in this Supplement in Section 1: Covered Services for Pediatric Vision Care Services.