HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Vision Care Services Rider

Option 6: 12/12/24/10-10-100

The Member Handbook and Evidence of Coverage ("EOC") between the Group and Health Plan of Nevada, Inc. (HPN), to which this Vision Care Services Rider ("Rider") is attached and incorporated therein, is amended to include the following vision care services:

SECTION 1. Vision Care Services

Subject to all definitions, terms and conditions in the EOC, a Member is entitled to receive the vision care services set forth in this Rider. The Member shall be entitled to vision care services only if (a) Lenses and Frames are prescribed by a Plan Provider and (b) the prescription was ordered while the Member was enrolled in HPN.

1.1 Examination

One vision examination by a Plan Provider to include complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities will be provided each 12 consecutive calendar month period.

1.2 Lenses

One pair of Lenses will be provided during any 12 consecutive calendar month period, without charge, if a prescription change is determined to be Medically Necessary by a Plan Provider. Lenses are limited to single vision, bifocal, trifocal, lenticular and other complex Lenses.

1.3 Frames

Expenses incurred in connection with Frames, from an approved frame selection, will be considered covered vision expenses once during each 24 consecutive calendar month period, up to a maximum allowance of $100.00. Charges for Frames in excess of the maximum allowance shall be the responsibility of the Member. Discounts may be available through the Plan Provider for those charges in excess of the maximum allowance.

1.4 Contact Lenses

Contact Lenses will be provided if a Member's visual acuity cannot be corrected to 20/70 in the better eye except for the use of Contact Lenses. In such event, Contact Lenses will be provided once during any 12 consecutive calendar month period. Contact Lenses are limited to single vision spherical Lenses. Such Covered Expenses shall be subject to a maximum allowance of $250.00. Charges for Contact Lenses in excess of the maximum allowance shall be the responsibility of the Member. Discounts may be available through the Plan Provider for those charges in excess of the maximum allowance

In addition, expenses incurred in connection with the purchase of one pair of Contact Lenses prescribed by a Plan Provider may be considered covered vision expenses, regardless of any visual acuity correction standards described above, on the condition that the Member elects to receive an allowance for the purchase of such Contact Lenses in lieu of all other vision benefits described in this Rider once during any 12 consecutive month period (with the exception of the annual vision examination which shall continue to be

available). Such Covered Expenses shall be subject to a maximum allowance of $115. Charges for Contact Lenses in excess of the maximum allowance shall be the responsibility of the Member. Discounts may be available through the Plan Provider for those charges in excess of the maximum allowance

1.5 Copayments

Examination: A Copayment of $10.00 is required for each vision examination by a licensed Plan Provider.

Plastic Lenses: A Copayment of $10.00 is required for Plastic Lenses, including Single Vision, Bifocal, Trifocal or Lenticular.

SECTION 2. Exclusions

In addition to any other applicable exclusions in the EOC, benefits shall not be provided for:

1. Lenses, Frames and/or Contact Lenses not prescribed by a Plan Provider;
2. Lenses, Frames and/or Contact Lenses prescribed:
   a) before the effective date of coverage, or
   b) after termination of coverage;
3. replacement of Lenses, Frames and/or Contact Lenses which are lost or broken;
4. orthoptics or vision training;
5. medical or surgical treatment of the eyes;
6. services or materials provided under Workers' Compensation; and
7. eye examinations required as a condition of employment or by a government body.

SECTION 3. Limitations

The following options are excluded from coverage hereunder; however, if the Member wishes to pay the full cost of any option, it will be made available by the Plan Provider. The Plan Provider will maintain a schedule listing the full cost of these options.

- oversize Lenses;
- cost of Frames in excess of frame allowance;
- tinted or photochromic Lenses;
- coated Lenses;
- cosmetic Contact Lenses;
- no-line bifocal Lenses;
- plastic multi-focal Lenses;
- two pairs of Lenses and Frames in lieu of bifocal Lenses and Frames; or
- all prescription sunglasses.

SECTION 4. General Provisions

4.1 This Rider shall be effective on the effective date of the EOC.

4.2 This Rider shall terminate upon termination of the EOC and under the same terms and conditions specified in the EOC. Upon such termination, Member shall cease to be entitled to any benefits provided in this Rider.

4.3 Nothing herein contained shall be held to vary, alter, waive or extend any of the terms, conditions, provisions, agreements or limitations of the EOC, other than as set forth in this Rider.

SECTION 5. Glossary

"Contact Lenses" shall mean ophthalmic corrective Lenses, either glass or plastic, ground or molded as prescribed by a Plan Provider to be fitted directly to the patient's eyes.

"Frames" shall mean standard eyeglass Frames adequate to hold two Lenses.

"Lenses" shall mean ophthalmic corrective Lenses, either glass or plastic, ground or molded as prescribed by a Plan Provider to be fitted into Frames.

"Plan Provider" means an ophthalmologist or optometrist who has agreed under an independent contract to provide vision care services to Members.