UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY

YOUR GROUP VISION PPO BENEFITS

FOR EMPLOYEES OF:

Trinity Management Services

CLASS(ES):

All Eligible Employees

EFFECTIVE DATE:

January 1, 2025

PUBLICATION DATE:

December 17, 2024

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. THE POLICY IS ISSUED IN THE STATE OF CALIFORNIA AND PROVIDES ALL OF THE BENEFITS REQUIRED BY APPLICABLE CALIFORNIA LAW.

THIS CERTIFICATE INCLUDES A PPO IN-NETWORK PROVIDER OPTION. YOUR OUT-OF-POCKET EXPENSES MAY BE GREATER WHEN USING AN OUT-OF-NETWORK PROVIDER.

THIS POLICY IS NOT IN LIEU OF AND DOES NOT AFFECT ANY REQUIREMENT FOR COVERAGE BY WORKERS' COMPENSATION INSURANCE.

A written list of In-Network Providers is available to you through:
www.mutualofomaha.com/vision or by calling customer service at: 1-833-279-4358

Group Number: G000CFQD

GVIS2018C CA

NOTICE

If a problem occurs, please first contact the Policyholder or your benefits administrator. If, after doing so, you still have a question or concern, you may contact us at:

United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-833-279-4358
www.mutualofomaha.com/vision

The Department of Insurance should be contacted only after the contacts between you and the Policyholder or your benefits administrator and your insurance company or its representatives have failed to produce a satisfactory solution to the problem. To contact the Department of Insurance, write or call:

Consumer Division
Department of Insurance, Los Angeles Office
300 South Spring Street
Los Angeles, California 90013
Consumer Services: 1-800-927-HELP (4357)
Consumer Services (TDD): 1-800-482-4TDD (4833)
www.insurance.ca.gov

TABLE OF CONTENTS

PAGE

CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number GUVC-CFQD (the Policy) has been issued to Trinity Management Services (the Policyholder).

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if you and your Dependents, if applicable, are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without your consent or notice to you.

This Certificate replaces any certificate previously issued under the Policy.

James T. Blackledge
Chief Executive Officer

Jay D. Vankat
Corporate Secretary

SCHEDULE

This Schedule describes some of the terms and conditions of the Policy including the benefits, Copayments, allowances, costs, exclusions and limitations. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate.

Benefits under the Policy may vary depending on the services or materials received In-Network or Out-of-Network.

All Providers are independent contractors; they are not our employees or agents. We do not supervise, control or guarantee the outcome or results of any services or materials furnished by any Provider. Your relationship with a Provider is that of provider and patient. The Provider is solely responsible for the services and materials provided to you.

POLICY INFORMATION

Policyholder:	Trinity Management Services
Policy Effective Date:	January 1, 2025
Policy Anniversary:	January 1
Policy Number:	GUVC-CFQD
Class(es):	All Eligible Employees
Coverage For:	You and your Dependents

GENERAL PROVISIONS

Work in Progress
Benefits will be provided for Vision Materials delivered after the date an Insured Person's insurance ends if such materials are ordered before coverage ended, and the Covered Services are rendered to the Insured Person within 31 days from the date of such order.

BENEFITS

Benefits are payable for each Insured Person under the Policy for Covered Services described in this section, subject to all terms and conditions of the Policy.

In-Network Benefits
Copayments or any cost above the allowance shown for Covered Services described in this section must be paid in full by the Insured Person to the In-Network Provider at the time a Covered Service is provided. We will pay benefits in excess of the Copayment for Covered Services to the In-Network Provider. The In-Network Provider will submit a claim to us on an Insured Person's behalf.

Out-of-Network Benefits
The Insured Person must pay the Out-of-Network Provider the full cost of services and materials at the time a Covered Service is provided. We will reimburse the Insured Person for benefits up to the Out-of-Network maximum dollar amount shown in this section after the Insured Person submits a claim to us.

Out-of-Area
An Insured Person who does not have access to an In-Network Provider within 20 miles of the Insured Person's residence may receive services from an Out-of-Area Provider. The Insured Person must pay the full cost of services and materials at the time a Covered Service is provided and submit a claim to us. Copayments or any cost above the allowance for In-Network benefits shown in this section must be paid in full by the Insured Person.

COVERED SERVICES

SERVICES	In-Network	Out-of-Network
Comprehensive Vision Examination	$10 Copayment	Up to $37
MATERIALS	**In-Network**	**Out-of-Network**
Frames	Up to $130 allowance	Up to $58
Standard Plastic Lenses		
• Single Vision	$25 Copayment	Up to $20
• Bifocal	$25 Copayment	Up to $36
• Trifocal	$25 Copayment	Up to $64
• Lenticular	$25 Copayment	Up to $64
Lens Options		
• Progressive Lenses – Standard (add on to Bifocal)	$65 Copayment	Up to $36
• Progressive Lenses – Premium (add on to Bifocal)	Tier 1: $85 Copayment Tier 2: $95 Copayment Tier 3: $110 Copayment Tier 4: $65 Copayment + 80% of charge, less applicable allowance	Up to $36 Up to $36 Up to $36 Up to $36
Contact Lenses (only one option available per Benefit Frequency)		
• Conventional	Up to $130 allowance	Up to $89
• Disposable	Up to $130 allowance	Up to $104
• Medically Necessary	Up to $0 Copayment	Up to $210
BENEFIT FREQUENCY		
• Examination	Once every 12 months	
• Lenses or Contact Lenses	Once every 12 months	
• Frame	Once every 24 months	

LIMITATIONS

Benefit allowances cannot be carried over and provide no remaining balance for future use within the same Benefit Frequency.

EXCLUSIONS

We will not pay benefits for any services or materials connected with or charges arising from:

a) orthoptic or vision training, subnormal vision aides and any associated supplemental testing;
b) Aniseikonic lenses;
c) medical or surgical treatment of the eye, eyes or supporting structures;
d) any eye or Vision Examination, or any corrective eyewear required by the Policyholder as a condition of employment;
e) safety eyewear;
f) services or materials provided or paid for in whole or in part by a state or federal government or its agencies;
g) services or materials provided or paid for in whole or in part as a result of any workers' compensation or occupational disease law or as required by any federal or state governmental agency or program;
h) Plano (non-prescription) lenses or contact lenses;
i) non-prescription sunglasses;
j) two pair of glasses in lieu of bifocals;
k) services or materials provided or paid for in whole or in part by any other group benefit plan providing vision benefits;
l) certain name brand Vision Materials for which the manufacturer maintains a no-discount practice;
m) services rendered after the date an Insured Person ceases to be covered under the Policy; or
n) lost, stolen, or broken lenses, frames, glasses, or contact lenses until the next Benefit Frequency when Vision Materials would next become available.

ELIGIBILITY

WHEN YOU BECOME ELIGIBLE FOR INSURANCE (ELIGIBILITY WAITING PERIOD)

If you are Actively Working on the Policy Effective Date, you become eligible for insurance on the Policy Effective Date.

If you are not Actively Working on the Policy Effective Date, or if you are hired after the Policy Effective Date, you become eligible for insurance on the day you begin Active Work.

The day you become eligible for insurance may not be the same as the day your insurance begins. The WHEN YOUR INSURANCE BEGINS provision describes the day your insurance begins.

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

Provided you elect insurance for you, your Dependents become eligible for insurance on the later of:

a) the day you become eligible for insurance; or
b) the day you acquire the Dependent.

If both you and your Spouse or Registered Domestic Partner are eligible for and elect insurance as Employees:

a) neither you nor your Spouse or Registered Domestic Partner may elect insurance as a Dependent of the other person; and
b) either you or your Spouse or Registered Domestic Partner, but not both, may elect insurance for your Dependent children.

The day a Dependent becomes eligible for insurance may not be the same as the day insurance begins. The WHEN YOUR DEPENDENT'S INSURANCE BEGINS provision describes the day when insurance begins.

WHEN YOUR INSURANCE BEGINS

You must enroll for any insurance requiring an election by submitting a Written Request for insurance. The Written Request must be submitted to the Policyholder no later than 31 days after the day you become eligible. If the Written Request for insurance is not submitted within the required timeframe, you may not enroll until a Subsequent Enrollment Period is offered.

You become insured on the first day of the month that follows the latest of the day:

a) you become eligible and are Actively Working; or
b) your Written Request is properly completed and signed, if required.

If you are not Actively Working when insurance would otherwise begin, insurance will not take effect until the day after you have completed one full day of Active Work.

WHEN YOUR DEPENDENT'S INSURANCE BEGINS

You must enroll your Dependents for any insurance requiring an election by submitting a Written Request for insurance. The Written Request must be submitted to the Policyholder no later than 31 days after the day your Dependent becomes eligible. If the Written Request for insurance is not submitted within the required timeframe, you may not enroll your eligible Dependents until a Subsequent Enrollment Period is offered.

An eligible Dependent will become insured on the latest of the day:

a) you become insured, unless otherwise agreed to by our authorized representative in our home office;
b) you acquire the eligible Dependent; or
c) your Written Request to enroll the Dependent for insurance is properly completed and signed, if required.

Insurance for a Dependent child who became Incapacitated prior to reaching the age of 26 begins in accordance with the above terms, provided the child otherwise meets the definition of Dependent.

Insurance for a newborn Dependent child begins at the moment of live birth, provided the child otherwise meets the definition of Dependent. Insurance for a newly adopted Dependent child begins with the date of placement into your custody, or at the moment of live birth if a written agreement to adopt the child was previously entered into by you, provided the child otherwise meets the definition of Dependent. If Dependent child insurance requires an election and Dependent child insurance for any other child is not already in effect, a Written Request for insurance for any newborn or newly adopted Dependent child must be submitted to the Policyholder within 31 days after the day the Dependent child becomes eligible in order to continue insurance beyond the 31-day period.

CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

If there is a conflict between this provision and any other provision of the Policy, this provision controls.

If the Policy replaces a Prior Plan, the Policy will provide insurance for you and any eligible Dependents if you:

a) were insured under the Prior Plan on the day before the Policy Effective Date;
b) are otherwise eligible, but not Actively Working on the Policy Effective Date due to:
    1. injury or sickness; or
    2. leave of absence protected under:
        a. the federal Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto; or
        b. any other applicable federal or state law that allows for continuation of insurance in certain instances;
c) are not insured under any provision of the Prior Plan;
d) are not a retired Employee; and
e) are approved by our authorized representative in our home office for insurance under this provision.

Insurance under this provision is subject to the following conditions:

a) insurance is subject to uninterrupted payment of premium to us when due; and
b) insurance is subject to all other terms and conditions of the Policy.

We reserve the right to request any information we need from the Policyholder to determine whether the conditions necessary to be eligible for insurance under this provision have been satisfied.

Insurance under this provision will end on the earliest of:

a) the day you return to Active Work for the Policyholder or begin employment with any other employer;
b) the last day you would have been insured under the Prior Plan, if the Prior Plan had not ended or terminated;
c) the day your insurance ends for any reason shown in the WHEN INSURANCE ENDS provision;
d) the last day of the twelfth month following the Policy Effective Date; or
e) the last day of the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation.

If you are eligible for insurance under this provision, you will not be eligible for insurance under any continuation provision in this Certificate.

FIRST ENROLLMENT PERIOD

You may elect insurance for you and any Dependents during the First Enrollment Period.

If you do not elect insurance during your or any Dependent's First Enrollment Period, future elections may only be made in accordance with the SUBSEQUENT ENROLLMENT PERIOD provision, or as otherwise provided under the WHEN ELECTION CHANGES ARE PERMITTED provision.

SUBSEQUENT ENROLLMENT PERIOD

You may elect, drop, or change insurance for you and any Dependents during a Subsequent Enrollment Period.

WHEN ELECTION CHANGES ARE PERMITTED

Life Events

The Policyholder has chosen to provide these insurance benefits under a Section 125 cafeteria plan. A cafeteria plan permits you to elect to pay your share of the cost of insurance with pre-tax dollars and permits you to change your elections only when specific life events occur, other than during a Subsequent Enrollment Period. You may make an election change by submitting a Written Request to the Policyholder within 31 days after the date of a life event.

Life events are described in the Policyholder's cafeteria plan. Contact the Policyholder for information regarding the election changes that are permissible under the Policyholder's cafeteria plan.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended in accordance with this provision. For any insurance requiring an election, you must submit a Written Request to reinstate insurance within 31 days of your return to Active Work. If the Written Request is submitted more than 31 days after the date you return to Active Work, you may not re-enroll for insurance until a Subsequent Enrollment Period is offered. If insurance is reinstated for you, insurance may also be reinstated for any eligible Dependents.

Reinstated insurance will take effect on the first day of the month that follows the date of the Written Request. If you are not Actively Working on the day the reinstated insurance would otherwise take effect, insurance will become effective on the day after you return to Active Work.

Non-Payment of Premium or Voluntary Termination of Insurance

If insurance ends because you do not pay premium or you voluntarily terminate insurance, you may not re-enroll for insurance until a Subsequent Enrollment Period is offered.

Involuntary Reduction in Hours

If insurance ends because you are no longer Actively Working due to an involuntary reduction of hours worked, insurance may be reinstated without satisfying another Eligibility Waiting Period if you return to Active Work and there was no break in employment with the Policyholder after the date insurance ended.

Rehired Employee Due to Layoff or Termination

If insurance ends because you are no longer Actively Working due to layoff or termination of employment with the Policyholder, insurance may be reinstated without satisfying another Eligibility Waiting Period if you are rehired and return to Active Work within 90 days from the date insurance ended.

Rehired Employee Due to Leave of Absence

If insurance ends because you are no longer Actively Working due to an approved leave of absence, insurance may be reinstated within 90 days from the date insurance ended without satisfying another Eligibility Waiting Period upon return to Active Work. If insurance ends because you are no longer Actively Working due to military leave, insurance may be reinstated upon return to Active Work within 31 days of your discharge from active duty without satisfying another Eligibility Waiting Period.

WHEN INSURANCE ENDS

Insurance ends on the earliest of:

a) for all Insured Persons, the last day of the month in which you are no longer Actively Working;
b) the last day of the month in which a Dependent is no longer eligible for insurance under the Policy;
c) the last day of the month in which your eligible Dependent child reaches the age of 26;
d) the last day of the month in which an Insured Person begins active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less), unless otherwise allowed in the Policy;
e) the day the Policy terminates; or
f) in accordance with the GRACE PERIOD provision.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for you and/or your Dependents would otherwise end, you and/or your Dependents may be able to continue insurance under one of the following provisions:

a) CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE
b) COBRA CONTINUATION

CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE

If there is a conflict between this provision and any other provision of the Policy, this provision controls.

You may be able to continue insurance for you and your Dependents from the day you cease to be Actively Working in the event of:

a) a temporary involuntary layoff; or
b) a leave of absence approved by the Policyholder due to:
    1. an injury or sickness; or
    2. any personal reason.

In addition, the federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain instances. Contact the Policyholder for additional information regarding any other continuation options that may be available.

Any insurance continued under this provision is subject to the following conditions:

a) insurance may not be continued beyond the earliest of:
    1. the end of the month for your temporary involuntary layoff;
    2. the end of the month for your leave of absence due to any personal reason; or
    3. the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation;
b) the amount of insurance for any Insured Person may not be increased while insurance is continued under this provision;
c) we receive verification of the approved layoff or leave from the Policyholder upon request; and
d) we continue to receive premium payment when due.

Insurance under this provision ends on the last day of the month which coincides with or follows the earliest of the day:

a) the time period in a) in the preceding paragraph has been satisfied;
b) your temporary involuntary layoff becomes permanent;
c) you return to Active Work;
d) you begin full-time employment with an employer other than the Policyholder; or
e) the Policy terminates.

Insurance under this provision also ends in accordance with the GRACE PERIOD provision.

See the OPTIONS FOR PAYMENT OF PREMIUM FOR APPROVED CONTINUATION OF INSURANCE provision in the Premium Payments section of this Certificate for premium payment options.

COBRA CONTINUATION

The COBRA CONTINUATION provision applies only if the Policyholder employed 20 or more employees on at least 50 percent of its business days during the preceding calendar year.

For You and Your Dependents

You and/or any insured Dependent who is a Qualified Beneficiary may elect to continue insurance under the Policy for as long as 18 months from the day your coverage ends because of these qualifying events:

a) your employment terminates (other than due to gross misconduct); or
b) you no longer satisfy the requirements for hours worked.

During the period you continue coverage:

a) any new eligible Dependents you acquire may be added in accordance with the WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE provision; and
b) any eligible Dependents you declined to insure before your continued insurance under the Policy began may be added during any open enrollment period provided by the Policy provided any additional premium is paid. However, such Dependents, other than a Qualified Beneficiary, who are added after the qualifying event will not be entitled to continue coverage as Qualified Beneficiaries after an event occurs as shown in the For Your Dependents Only section below.

For Your Dependents Only

Your insured Spouse or Registered Domestic Partner who is a Qualified Beneficiary and/or each of your insured Dependent children who is a Qualified Beneficiary may elect to continue insurance under the Policy for as long as 36 months from the day coverage ends because of these qualifying events:

a) you die;
b) you become entitled to Medicare benefits;
c) you and your Spouse or Registered Domestic Partner are legally separated;
d) your marriage is ended by divorce; or
e) a child is no longer an eligible Dependent.

If your Dependent is already continuing coverage under the *For You and Your Dependents* section above when an event shown in the *For Your Dependents Only* section occurs, that second event will not entitle your Dependent to continue coverage beyond 36 months under the *For You and Your Dependents* and *For Your Dependents Only* sections combined.

If your Dependent becomes entitled to continue insurance under both the *For You and Your Dependents* and *For Your Dependents Only* sections on the same day, the periods of continued coverage will run concurrently and will not exceed 36 months.

Notice Requirements

Your employer is required by law to notify the Plan Administrator within 30 days after your termination of employment, reduction in hours, death or entitlement to Medicare. You must notify the Plan Administrator within 60 days after the day you are legally separated or divorced, or your child ceases to be an eligible Dependent.

If an Insured Person is determined, in accordance with Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continued coverage, that person must:

a) notify the Plan Administrator within 60 days of the date of the determination and before the first 18 months of continued coverage ends; and
b) notify the Plan Administrator within 30 days of the date of any final determination that he or she is no longer disabled. Then, continued coverage ends the first day of the month that begins more than 30 days after the date of such final determination.

Within 14 days after receiving notice of a qualifying event, the Plan Administrator will send you or your Dependent written notice of the continuation right. The Plan Administrator must receive your or your Dependent's written request to continue insurance under the Policy within 60 days after the day:

a) insurance ends; or
b) the Insured Person is sent notice of the continuation right; whichever is later.

PREMIUM PAYMENTS

PAYMENT OF PREMIUM THROUGH PAYROLL DEDUCTION

You are responsible for the payment of your share of the premium for insurance under the Policy. The premium owed by you equals the total of your share of the premium for all Insured Persons.

Premium is automatically deducted from your pay by the Policyholder, then remitted to us, as authorized by you during the enrollment process. Please contact the Policyholder for information regarding your deductions.

Payment of premium does not guarantee eligibility for coverage.

OPTIONS FOR PAYMENT OF PREMIUM FOR APPROVED CONTINUATION OF INSURANCE

When insurance is continued, we must receive premium payment when due for insurance to remain effective. Premium payment may be made in the following ways:

a) the Policyholder may pay the premium; or
b) you may pay premium to the Policyholder who will then submit premium to us.

Contact the Policyholder to determine which option is available to you.

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

There is a grace period of 60 days for payment of premiums. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 60-day period that follows. We will consider premium to be paid on the date we receive it.

Insurance will stay in force during the grace period as long as premium is paid before the end of the grace period. If we receive written notice requesting cancellation of insurance on a current or future date, the grace period will not apply. Coverage will end on the cancellation date specified in such notice, as long as the full premium has been paid up to that date.

If premium is not paid by the end of the grace period, insurance will end the day after the last day of the grace period.

PREMIUM AND PREMIUM CHANGES

The premium for insurance under the Policy is a monthly rate that applies to you and your Dependents.

If you request a change in the amount of insurance for any Insured Person, the Policyholder will provide you with notice of your new premium amount upon request if you are responsible for the payment of premiums for insurance.

If there is a change in the amount of the premium for insurance for any Insured Person in accordance with the terms of the Policy, or a change in the amount of insurance for any Insured Person as the result of a request of the Policyholder, the Policyholder will provide you with notice of the change at least 15 days prior to the date of the change if you are responsible for the payment of premium for insurance.

Premium amounts will change if premium rates under the Policy change.

CLAIMS PROVISIONS

CLAIM FORMS

Before benefits can be considered, we must be given written notice of claim. A claim form can be requested from your Provider, from us or obtained on our website. A request for a claim form should be made within 20 days after a Covered Service occurs or as soon as reasonably possible. If we do not provide a claim form within 15 days of the request, written proof of claim may by submitted that includes the nature, date, cause and extent of the Covered Services for which the claim is made.

You do not need to submit a claim form to us if services are received In-Network. If services are received Out-of-Network, you must submit a claim form to us.

PROOF OF CLAIM

Written proof must be given to us within 90 days from the date of service. If it is not reasonably possible to give us proof within the required time, we will not deny a claim filed for this reason if the proof is supplied as soon as reasonably possible, unless you are legally incapable.

We may require supporting information which may include, but is not limited to, clinical records, charts, x-rays, and other diagnostic aids.

INDEPENDENT EXAMINATION

We may require an Insured Person to be examined by a Provider as we direct to assist in determining whether benefits are payable.

We will pay for these examinations. We will not require more than a reasonable number of such examinations.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
First American Administrators, Inc.
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
First American Administrators, Inc.
P.O. Box 8504
Mason, OH 45040
Call Toll-Free: 1-833-279-4358

PAYMENT OF CLAIMS

Benefits will be paid immediately after we receive acceptable written notice of claim and any other required supporting information.

Benefits will be paid to the Provider if services are received In-Network. If services are received Out-of-Network, benefits will be paid to you, unless you or your Dependent have assigned benefits to the Provider.

Benefits unpaid at your death will be paid to:

a) any relative who is entitled to the benefits; or
b) your estate.

With each claim payment, we will provide you an explanation of benefits that includes the name of the Provider, services submitted, amount charged, dates of service and a reasonable explanation of the computation of benefits.

CLAIM REVIEW AND APPEAL PROCESS

Claim Review

We will notify the Claimant in writing of our decision to either approve or deny a claim within 45 days of the date it is received by us. If we deny a claim in whole or in part, we will explain the reasons for our denial in our notice. If the Claimant disagrees with the reasons given, the Claimant, or authorized representative of such person, may ask that we reconsider the claim through the appeal process.

Appeal Process

To appeal a denied claim, the Claimant must notify us and ask that we reconsider our original benefit decision within 180 days after receiving notice of our denial. The Claimant's appeal request must be submitted to us in writing and should state the reasons why the Claimant believes the claim denial was incorrect. Any additional information, documents or other materials that might allow us to change our original decision should also be included. Appeal requests must be sent to us at our address shown in the CLAIM ASSISTANCE provision.

The request for an appeal should include:

a) the Policyholder's name and the Policy number;
b) the patient's name and date of birth;
c) the date of service to be reviewed;
d) the Employee name, Member ID, and mailing address;
e) the name and address of the treating Provider; and
f) the reason for the appeal.

By requesting an appeal, you have authorized us, or anyone designated by us, to review any and all records (including medical/vision records) which may be relevant to your appeal.

We will notify the Claimant in writing of our final claim decision within 30 days after receiving the appeal request. If we need more time due to circumstances beyond our control, we will inform the Claimant of our need for an extension prior to the end of this time frame.

Notice

If the administration of the Policy is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Claimant may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of a claim or to ask questions about the Claimant's rights under ERISA.

REFUND TO US

If it is found that we paid more benefits than we should have paid under the Policy, we will have the right to a refund from you or the recipient of benefits.

We also have a right to a refund for any payments due to:

a) fraud or misrepresentation;
b) any error we make in processing a claim;
c) you or your agent's failure to provide complete information; or
d) an Insured Person not being eligible for coverage.

You or the recipient of benefits must reimburse us in full. We will determine the method the repayment is to be made, including without limitation, reducing or withholding any benefits payable under this or any other group insurance policy issued by us. We will credit any such payments to the refund until the refund is fully recovered.

If it is found that we paid less benefit than we should have paid under the Policy, we will make additional payments, as necessary.

STANDARD PROVISIONS

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy (which includes this Certificate); and
b) the Policyholder's signed application attached to the Policy.

Any statement made by the Policyholder or you will, in the absence of fraud, be considered a representation and not a warranty.

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time we and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require the consent of any Insured Person or beneficiary; and
b) must be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by one of our home office executive officers.

A change may affect any class of Insured Persons included in the Policy.

DELEGATION

We may delegate some of our obligations and responsibilities under the Policy, such as claims administration, network management and other administrative services, to a third party designated by us. Any delegation of obligations and responsibilities will be done in compliance with applicable California law and in no way relieves us from responsibility for the actions taken and decisions made by such third party.

INCONTESTABILITY

We will not contest this Policy after it has been in force for two years during an Insured Person's lifetime, except for nonpayment of premium.

Statements in an application are considered representations and not warranties. We will not use any statements in an Insured Person's application to deny a claim or to contest the validity of this insurance unless we provide you, your beneficiary or legal representative with a copy of that application.

LEGAL ACTIONS

No action at law or in equity will be brought to recover on this Policy prior to the expiration of 60 days after written notice of claim has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of three years after the time notice of claim is required to be furnished, unless otherwise required by state law in your state of residence.

CONFORMITY WITH STATE AND FEDERAL LAW

Any provision of the Policy which, on its effective date, is in conflict with the law of the federal government or the state in which an Insured Person resides on such date is hereby amended to conform to the minimum requirements of such law.

DEFINITIONS

The defined terms used in this Certificate and Policy are shown in this section. With the exception of *our, we, us, you, your* and *yourself*, we have capitalized these terms wherever they appear to make them easier for you to find.

The definitions set forth below apply to both the singular and plural versions of the defined term.

Actively Working, *Active Work* means you are:

a) performing the normal duties of your job for the Policyholder on a regular and continuous basis 30 or more hours each week; and
b) receiving compensation from the Policyholder for work performed for the Policyholder.

You will be considered to be actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided you were actively working on the last preceding regular work day.

Benefit Frequency means the period of time in which a benefit is payable. The benefit frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new benefit frequency begins at the expiration of the previous benefit frequency.

Certificate means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

Claimant means the person who submits a claim for benefits for any Insured Person, including the authorized representative of such person.

Copayment means the designated amount, if any, shown in the Schedule each Insured Person must pay to a Provider before benefits are payable for a covered Vision Examination or Vision Materials each Benefit Frequency.

Covered Service means a vision examination or materials that are:

a) described in the Schedule as a covered examination or materials for which benefits are payable;
b) performed by a Provider; and
c) assigned a procedure code which is generally accepted by the vision insurance industry.

Dependent means a citizen, permanent resident or lawful resident of the United States who is:

a) your Spouse or Registered Domestic Partner;
b) your natural born, legally adopted or foster child;
c) your stepchild (or child of your domestic partner, civil union partner or equivalent);
d) a child that you or your Spouse or Registered Domestic Partner are required to provide insurance for under the terms of a decree, judgment or order issued by a court of competent jurisdiction;
e) any other child who lives with you in a regular parent/child relationship and who qualifies as your dependent as defined in the United States Internal Revenue Code; or
f) an Incapacitated person for whom you have been appointed legal guardian and who qualifies as your dependent as defined in the United States Internal Revenue Code.

A dependent does not include:

a) anyone insured as an Employee;
b) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less);
c) your divorced, legally separated, or former Spouse or Registered Domestic Partner;
d) a child who has reached the age of 26, unless the child is Incapacitated;
e) your child who is married (or in a domestic partnership, civil union partnership, or equivalent);
f) your child if the child has been legally adopted by another person; or
g) a child placed in your home by a social service agency which retains control over the child.

Eligibility Waiting Period means a continuous period of Active Work that you must satisfy before becoming eligible for insurance as described in the WHEN YOU BECOME ELIGIBLE FOR INSURANCE (ELIGIBILITY WAITING PERIOD) provision.

Employee means a person who is:

a) a citizen or permanent resident of the United States; or
b) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
c) receiving compensation from the Policyholder for work performed for the Policyholder at:
    1. the Policyholder's usual place of business;
    2. an alternative work site at the direction of the Policyholder; or
    3. a location to which the employee must travel to perform the job.

An employee does not include a person:

a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from our authorized representative in our home office;
b) working for the Policyholder on a seasonal or temporary basis; or
c) performing services for the Policyholder as an independent contractor, including persons for whom income is reported on a 1099 form or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

First Enrollment Period means the 31-day period following the day you or your Dependent becomes eligible for insurance under the Policy or any Prior Plan.

Incapacitated means a Dependent that is continuously incapable of self-sustaining employment by reason of intellectual disability, developmental disability, mental illness, or physical disability.

In-Network means any benefit, service, or material furnished by a Provider who has agreed to accept a specific amount as payment in full for Covered Services through participation in the PPO.

Insured Person means you and/or your Dependent who is insured under the Policy.

Medically Necessary means contact lenses are necessary:

a) due to Keratoconus where vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;
b) due to High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
c) due to Anisometropia of 3D in spherical equivalent or more; or
d) when vision can be corrected by two lines of improvement on the visual acuity chart when compared to a best corrected standard spectacle.

Our, We, Us means United of Omaha Life Insurance Company.

Out-of-Network means any benefit, service or material furnished by a Provider who does not participate in the PPO and has not agreed to accept a negotiated amount as payment in full for Covered Services.

Out-of-Area Provider means an Out-of-Network Provider that is utilized by an Insured Person when there is no In-Network Provider within 20 miles of the Insured's residence.

Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group vision insurance plan.

Policy means the group policy issued to the Policyholder by us, including this Certificate.

Policyholder means Trinity Management Services.

Policy Anniversary means January 1 of each Policy Year.

Policy Effective Date means January 1, 2025.

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

Prior Plan means any similar insurance policy:

a) replaced by insurance under part or all of the Policy; and
b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

Preferred Provider Agreement means an agreement between the PPO and Provider that contains the rates and reimbursement methods for Covered Services provided by such Provider.

Preferred Provider Organization ("PPO") means a network of Providers and retail chain stores that has signed a Preferred Provider Agreement.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician.

Qualified Beneficiary means any individual who, on the day before the qualifying event, is an Insured Person under the Policy. Qualified Beneficiary also includes a child who is born or is placed for adoption with you during the period of continued coverage.

Registered Domestic Partner means a pair of adults who have registered themselves as domestic partners in accordance with state law.

Spouse means the person to whom you are legally married.

Subsequent Enrollment Period means any period designated for enrollment by the Policyholder and agreed to in writing by our authorized representative in our home office.

Vision Examination means any eye or visual examination covered under the Policy and shown in the Schedule.

Vision Materials means lenses, frames and contact lenses as shown in the Schedule.

Written Request means a request that is signed, dated and submitted to the Policyholder or us. The request must be on a form we supply or be in a form and content acceptable to us.

You, Your means the Employee who may be eligible or insured under the Policy.

ADDITIONAL SUMMARY PLAN DESCRIPTION INFORMATION

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an employee benefits plan. The employee benefits plan maintained by the Policyholder shall be referred to herein as the "Plan."

This document, in conjunction with Your Certificate, is Your ERISA Summary Plan Description for the insurance benefits described herein. However, this Certificate does not include complete information regarding the election changes which may be permissible under the Policyholder's Internal Revenue Code Section 125 cafeteria plan. Your plan administrator will provide You with information regarding the election changes that are permissible under the cafeteria plan.

Contributions are made by the Policyholder and by participants. Contributions are based on the amount of insurance premiums necessary to provide Plan coverage.

The benefits under the Plan are fully insured by us under a group insurance policy issued by us. Benefits under the Policy are guaranteed to the extent all Policy provisions are met and subject to all terms and conditions of the Policy (including, but not limited to, all exclusions, limitations and exceptions in the Policy). Our home office is located at Mutual of Omaha Plaza, Omaha, NE 68175.

The Employer Identification Number (EIN) is: 94-2553354
The Plan Number is: 502

PLAN ADMINISTRATOR

The Plan is provided through and administered by:

Trinity Management Services
1145 market st
ste 1200
San Francisco, CA 94103
Phone: (650) 284-6222

AGENT FOR SERVICE OF LEGAL PROCESS

The agent for service of legal process upon the Plan is:

Trinity Management Services
1145 market st
ste 1200
San Francisco, CA 94103
Phone: (650) 284-6222

PLAN YEAR

Each 12-month period beginning on January 1 is a "plan year" for the purposes of accounting and all reports to the U.S. Department of Labor and other regulatory bodies.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

a) Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series)

filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

b) Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a benefit or exercising Your rights under ERISA.

c) Enforce Your Rights

If Your claim for a benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

d) Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration

PLAN DISCLOSURES

You are entitled to request from the Plan Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, Your Certificate includes, as applicable, a description of:

a) employee eligibility requirements;
b) when insurance ends;
c) state or federal continuation rights; and
d) claims procedures.

PLAN CHANGES

The persons with authority to change, including the authority to terminate, the Plan on behalf of the Policyholder are the Policyholder's Board of Directors or other governing body, or any person or persons authorized by resolution of the Board or other governing body to take such action. Please refer to the provision in Your Certificate entitled "Changes in the Insurance Contract" for information about how the Policy can be changed. The Policyholder's benefits area is authorized to apply for and accept the Policy and any changes to the Policy on behalf of the Policyholder.

Group Vision Benefits

Trinity Management Services

Group Number: G000CFQD

United of Omaha Life Insurance Company

Home Office:
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175