G.E.H.A Connection Vision® Plan

Powered by EyeMed Vision Care

www.geha.com
877-434-2336

G.E.H.A Government Employees Health Association

2026

Eligible G.E.H.A members and their eligible dependents who are covered by any of the following plans are automatically enrolled:

- G.E.H.A Federal Employee Health Benefit (FEHB) Plan members –
  - High Option*
  - Standard Option*
  - Elevate
  - Elevate Plus
- G.E.H.A Postal Service Health Benefit (PSHB) Plan members –
  - High Option*
  - Standard Option*
- G.E.H.A Federal Employee Dental and Vision Insurance Program (FEDVIP) members –
  - High Option
  - Standard Option
- G.E.H.A Connection Dental Plus members

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* Members who enroll in the G.E.H.A Medicare Advantage Plan receive vision coverage as part of that health plan and therefore are not eligible for The Vision Plan.

Introduction

This brochure describes the Connection Vision Plan ("The Vision Plan") benefits that are part of the Government Employees Health Association, Inc. Voluntary Welfare Benefit Plan ("Plan"). The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA). This brochure constitutes not only a part of the Summary Plan Description required by ERISA Section 102, but is incorporated into and forms part of the actual Plan Document, written in a manner so that it can readily be understood and used by You and by G.E.H.A in administering The Vision Plan.

Contact Information:
For questions or to find an in-network provider, call EyeMed Customer Service at (877) 808-8538 Monday through Saturday from 8 am until 11 pm EST and Sundays from 11 am until 8 pm EST, or visit www.geha.com, choose your benefit program, select included benefits, and then vision benefits.

Name of the Plan
The Vision Plan shall be known as the Government Employees Health Association, Inc. Connection Vision powered by EyeMed, which is part of the Government Employees Health Association, Inc. Voluntary Welfare Benefit Plan.

Type of Administrator
Benefits administered by EyeMed Vision Care LLC.; Underwritten by Fidelity Security Life Insurance Company®, Kansas City, Missouri 64108.

Plan Numbers

EyeMed Plan Number	G.E.H.A Plan(s)
1023962	FEHB Elevate Plan
1023963	FEHB Elevate Plus Plan
9787961	FEHB High/Standard Plans PSHB High/Standard Plans FEDVIP High/Standard Plans Connection Dental Plus Plan
9787979	FEHB HDHP Plan
1056181	PSHB HDHP Plan
9787979 – 7031	New Mexico Plan Members

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How We Have Changed For 2026

Benefit Changes:

FEHB & PSHB Plans: High, Standard, Elevate, Elevate Plus

Eye exam copays increased to $20.

FEDVIP Plans: High and Standard

Eye exam copays increased to $20.

Connection Dental Plus

Eye exam copays increased to $20.

Connection Vision Program Highlights

Effective Date of Coverage

If all Enrollment Requirements are met, then you or your Dependent(s)' coverage will be effective on the first day of your G.E.H.A health or dental plan coverage. Coverage for any Eligible Dependent(s) will become effective only on or after your Effective Date of Coverage. All Eligible Dependents enrolled more than 31 days after your Eligibility Date will have a separate Effective Date of Coverage. An Eligible Person or Dependent shall become a Covered Person on the date coverage for such person begins.

Enrollment Period

The Enrollment Period is the time period that begins with you or your Dependent(s)' Eligibility Date and ends when you are no longer an Eligible Person.

Compliance with Employee Retirement Income Security Act of 1974 (ERISA)

The Vision Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA). We intend to maintain The Vision Plan indefinitely. However, we have the right to modify or terminate The Vision Plan at any time, and for any reason, as to any part or in its entirety, without advance notice. If The Vision Plan is amended or terminated, you will not receive benefits described in the vision brochure after the effective date of such amendment or termination. Any such amendment or termination shall not affect your right to benefits for claims incurred prior to such amendment or termination. If The Vision Plan is amended, you may be entitled to receive different benefits or benefits under different conditions. However, if The Vision Plan is terminated, all benefit coverage would end. This may happen at any time, and in no event will you become entitled to any vested rights under The Vision Plan.

You are entitled to this coverage if the provisions in this vision brochure have been satisfied. This vision brochure is void if you have ceased to be entitled to coverage. No clerical error will invalidate your coverage if otherwise validly in force. Oral statements cannot modify the benefits described in this brochure.

Choice of Vision Practitioner

Each Covered Person has the right to choose any licensed Optical Practitioner. If you use a Participating EyeMed Provider, you will pay the Copay noted in the Benefit Schedule found in this brochure. If you use a non-participating provider, you will need to submit the claim to receive a reimbursement of up to the out-of-network amount shown in the Benefit Schedule. See How to File Claims section in this brochure.

Premium

The full cost will be handled by G.E.H.A for Eligible Members and Eligible Dependents who are actively covered by a G.E.H.A Heath Plan, G.E.H.A Connection Dental Federal Plan, or G.E.H.A Connection Dental Plus. Members who elect COBRA continuation of coverage under one of the foregoing plans will automatically receive COBRA continuation of The Vision Plan coverage for no additional COBRA premiums. G.E.H.A reserves the right to charge a Premium to Eligible Members and Eligible Dependents in the future.

Section 1 Eligibility

Member Eligibility

Subject to the exclusions noted below, your eligibility will be automatic for yourself and your Eligible Dependent(s) after your first day of your G.E.H.A health or dental plan coverage. Members in the following G.E.H.A plan(s) are eligible:

- G.E.H.A FEHB Plan members –
  - High Option
  - Standard Option
  - Elevate
  - Elevate Plus
- G.E.H.A PSHB Plan members –
  - High Option
  - Standard Option
- G.E.H.A FEDVIP members –
  - High Option
  - Standard Option
- G.E.H.A Connection Dental Plus members

Eligibility Date

You are eligible for coverage on the date you are an Eligible Person as a member of the Government Employees Health Association.

Your Eligible Dependent(s) will be eligible for coverage on the later of:

- Your Eligibility Date; or
- The date the Dependent first becomes an Eligible Dependent.

If an Eligible Dependent is also an Eligible Member, he or she will be eligible for coverage as a Member or as a Dependent, but not as both.

Not Eligible

Notwithstanding the above, the following persons are not eligible for The Vision Plan regardless of FEHB/ PSHB/ FEDVIP/ Connection Dental Plus enrollment:

- Members who enroll in the G.E.H.A Medicare Advantage Plan receive vision coverage as part of that health plan and therefore are not eligible for The Vision Plan. See your medical benefit brochure for details - https://retiree.uhc.com/geha/coverage-and-benefits.
- Members with the G.E.H.A High Deductible Health Plan (HDHP) receive vision coverage as part of that health plan and therefore are not eligible for The Vision Plan. See your medical benefit brochure for details - https://www.geha.com/savings/vision-coverage-hdhp.

Section 2 Enrollment

Effective Date of Coverage

If all Enrollment Requirements are met, then you or your Dependent(s)' coverage will be effective on the first day of your G.E.H.A health or dental plan coverage. Coverage for any Eligible Dependent(s) will become effective only on or after your Effective Date of Coverage. All Eligible Dependents enrolled more than 31 days after your Eligibility Date will have a separate Effective Date of Coverage. An Eligible Person or Dependent shall become a Covered Person on the date coverage for such person begins.

Enrollment Requirements

Your enrollment will be automatic for yourself and your Eligible Dependent(s) after your Coverage Effective Date for your G.E.H.A health and/or dental plan.

When Coverage Terminates

Member - Your coverage will terminate on the date you no longer are eligible as a Covered Person.

Dependents - Your covered Dependent(s)' coverage under The Vision Plan will end on the earliest of the following dates:

- The date your coverage under The Vision Plan terminates;
- The date The Vision Plan is amended so as to terminate the Dependent(s)' coverage;
- The date on which the Dependent ceases to be an Eligible Dependent.

Termination Does Not Affect Existing Claims
When a Covered Person's coverage is terminated for any reason other than Involuntary Termination for Fraudulent Claims, such termination does not affect any claims for Covered Services that were incurred and completed while the Covered Person's coverage was in force (assuming any required Premium has been paid).

Involuntary Termination for Fraudulent Claims
If any Covered Person knowingly submits or participates in the submission of information that contains false or misleading facts, then we have the right to revoke that Covered Person's coverage.

Section 3 How You Obtain Care

Identification Cards/ Enrollment Confirmation	EyeMed will send you an enrollment welcome letter including an ID Card when you enroll. While ID cards are provided, they are not required to obtain service. Members may print a copy online from www.EyeMed.com or call EyeMed Customer Service at (877) 808-8538 to verify your eligibility in the plan. Note that ID Cards will only list the subscriber's information regardless of if there are additional dependents enrolled on the plan.
Plan Providers	EyeMed lists plan providers in the provider directory, which is updated bi-annually. The provider directory is located on G.E.H.A's vision page at https://eyedoclocator.eyemedvisioncare.com/geha. It is your responsibility to ensure that the provider chosen is an active participant in the program at the time you receive services. In some cases, due to local regulations or business practices, the doctor may be independent of the retail location. You should confirm that both the doctor and the retail location are participating prior to seeking services.
Pre-Determination	The plan does not require a pre-determination of benefits.

Section 4 Your Cost For Covered Services

Allowance	An allowance refers to the amount of money provided by EyeMed to cover the cost of eyeglass frames or lenses. This allowance is designed to help individuals purchase their eyeglasses without incurring the full expense upfront.
Copayment	A copayment or copay is a fixed amount of money you pay to the provider when you receive services.
In-Network Services	EyeMed negotiates rates with vision care providers and other health care providers to help save you money. EyeMed in-network providers are contracted through EyeMed Vision Care. When scheduling an appointment, you should identify yourself as a member of the Connection Vision plan. The provider is then responsible for verifying eligibility by contacting EyeMed either by telephone or via the web. We refer to these providers as "in-network providers." If you use in-network providers to obtain care, benefits are paid at the in-network level. You are responsible for covered charges up to our negotiated plan allowance.
Out-of-Network Services	You may obtain care from any licensed eye care provider. If the provider you use is not part of the EyeMed network, benefits will be considered out-of-network. Because these providers are out-of-network, we will reimburse you up to the maximum reimbursement amount allowed by the plan. You are responsible to pay the out-of-network provider and then submit a claim to receive your reimbursement. Connection Vision is a nationwide plan and does not have network doctors overseas. To obtain services, visit any international eye care provider and you will be reimbursed out-of-network schedule.
Out-of-Network Reimbursement	For select benefits, G.E.H.A will reimburse members a fixed amount for healthcare services received from providers who are not contracted with EyeMed.
Promotional Price	A reduced price for a product which could be done through a sale, discount, or special offer.
Retail Price	The price that a product's manufacturer recommends that it be sold at.

Section 5 Connection Vision Plan Benefits

The chart below outlines benefits for G.E.H.A members who reside **outside the state of New Mexico**.

EyeMed Vision Benefits **Plan Year: 2026**	**FEHB/PSHB: High, Standard, Elevate, Elevate Plus** **FEDVIP: High, Standard** **Connection Dental Plus**	
	In-Network You Pay	**Out-of-Network** **Reimbursement**[1]
Eye Exam	$20 copay	$45
Retinal Imaging Benefit	Up to $39	N/A
Contact Exam Options		
Standard Contact Lens Fit and Follow-Up	All charges	N/A
Premium Contact Lens Fit and Follow-Up	All charges	N/A
Frame[2]	40% off Retail Price	N/A
Standard Plastic Lenses:		
Single Vision	$50 copay	N/A
Bifocal	$70 copay	N/A
Trifocal	$105 copay	N/A
Lenticular	20% off Retail Price	N/A
Standard Progressive Lens	$135 copay	N/A
Premium Progressive Lens	20% off Retail Price	N/A
Lens Options[3]*:*		
UV Treatment	$15 copay	N/A
Tint (Solid and Gradient)	$15 copay	N/A
Standard Plastic Scratch Coating	$15 copay	N/A
Standard Polycarbonate - Adults	$40 copay	N/A
Standard Polycarbonate - Kids <19	$40 copay	N/A
Standard Anti-Reflective Coating	$45 copay	N/A
Premium Anti-Reflective Coating	20% off Retail Price	N/A
Polarized	20% off Retail Price	N/A
Photochromic/Transitional Plastic	All Charges	N/A
Other Add-On's	20% off Retail Price	N/A
Contact Lenses[4]*:*		
Conventional	15% off Retail Price	N/A
Disposable	All Charges	N/A
Medically Necessary	All Charges	N/A
Laser Vision Correction	15% off Retail Price; 5% off Promotional Price	N/A

	FEHB/PSHB: High, Standard, Elevate, Elevate Plus **FEDVIP: High, Standard** **Connection Dental Plus**
Frequency:	
Examination	Once Every Calendar Year
Frame	Unlimited
Lenses (in lieu of contact lenses)	Unlimited
Contact Lenses (in lieu of lenses)	Unlimited

[1]: Member reimbursement out-of-network will be the lesser of the listed amount of the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.

[2]: For complete pair eyeglasses purchase discounts, frame, lenses, and lens options must be purchased in same transaction to receive full discount.

[3]: Frame, lens, and lens option discounts apply only when purchasing a complete pair of glasses. If purchased separately, members receive 20% off the retail price.
[4]: Discount applied to materials only.

The chart below outlines benefits for G.E.H.A members who reside **in the state of New Mexico**.

EyeMed Vision Benefits **Plan Year: 2026**	**FEHB/PSHB: High, Standard, Elevate, Elevate Plus** **FEDVIP: High, Standard** **Connection Dental Plus** **(New Mexico Members Only)**	
	In-Network You Pay	**Out-of-Network** **Reimbursement[1]**
Eye Exam	$5 copay	$45
Retinal Imaging Benefit	Up to $39	N/A
Contact Exam Options		
Standard Contact Lens Fit and Follow-Up	$40 copay	N/A
Premium Contact Lens Fit and Follow-Up	10% off Retail Price	N/A
Frame	Nothing for frames up to $50 allowance. Additionally, a 20% discount applies to any amount over $50	$25
Standard Plastic Lenses:		
Single Vision	$25 copay	$25
Bifocal	$25 copay	$40
Trifocal	$25 copay	$55
Lenticular	$25 copay	$55
Standard Progressive Lens	$90 copay	$40
Premium Progressive Lens	See Fixed Premium Progressive Price List	$40
Lens Options:		
UV Treatment	$15 copay	N/A
Tint (Solid and Gradient)	$15 copay	N/A
Standard Plastic Scratch Coating	$15 copay	N/A
Standard Polycarbonate - Adults	$40 copay	N/A
Standard Polycarbonate - Kids <19	Nothing	$5
Standard Anti-Reflective Coating	$45 copay	N/A
Premium Anti-Reflective Coating	See Fixed Premium Anti-Reflective Coating List	N/A
Polarized	20% off Retail Price	N/A
Photochromic/Transitional Plastic	$75 copay	N/A
Other Add-On's	20% off Retail Price	N/A
Contact Lenses:		
Conventional	$0 Copay; $50 Allowance; 15% off Balance Over $50	$40
Disposable	$0 Copay; $50 Allowance; Plus Balance Over $50	$40
Medically Necessary	Nothing	$210
Laser Vision Correction	15% off Retail Price; 5% off Promotional Price	N/A

Frequency:	**FEHB/PSHB: High, Standard, Elevate, Elevate Plus FEDVIP: High, Standard Connection Dental Plus (New Mexico Members Only)**
Examination	Once Every Calendar Year
Frame	Once Every Two Calendar Years
Lenses (in lieu of contact lenses)	Once Every Calendar Year
Contact Lenses (in lieu of lenses)	Once Every Calendar Year

Pricing Lists

	In-Network Member Cost (New Mexico Members Only)
Progressive Price List[5]*:*	
Standard Progressive	$90 copay
Premium Progressive – Tier 1	$110 copay
Premium Progressive – Tier 2	$120 copay
Premium Progressive – Tier 3	$135 copay
Premium Progressive – Tier 4	$90 Copay; 20% off Charge Less $120 Allowance
Anti-Reflective Coating Price List[5]:	
Standard Anti-Reflective Coating	$45 copay
Premium Anti-Reflective Coating – Tier 1	$57 copay
Premium Anti-Reflective Coating – Tier 2	$68 copay
Premium Anti-Reflective Coating – Tier 3	20% off Retail Price
Other Add-On's Price List:	
Photochromic (Plastic)	$75 copay
Polarized	20% off Retail Price

[1]: Member reimbursement out-of-network will be the lesser of the listed amount of the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.
[5]: Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

Section 6 General Exclusions – Things We Do Not Cover

Limitations

- Fees charged by a Provider for services other than a covered benefit and any local, state, or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy.
- Allowances provide no remaining balance for future use within the same Benefit Frequency.
- Some provisions, benefits, exclusions, or limitations listed herein may vary by state.

Exclusions

No benefits will be paid for services or materials connected with or charges arising from:

- Medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures.
- Refraction, when not provided as part of a Comprehensive Eye Examination.
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
- Any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear;
- Solutions, cleaning products or frame cases;
- Non-prescription sunglasses;
- Plano (non-prescription) lenses;
- Plano (non-prescription) contact lenses;
- Two pair of glasses in lieu of bifocals;
- Electronic vision devices;
- Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order;
- Lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Plan Discounts

- Member receives a 20% discount on items not covered by the plan at In-Network locations. Discount does not apply to Provider's professional services or contact lenses.
- Plan discounts cannot be combined with any other discounts or promotional offers.
- In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see the online provider locator to determine which participating providers have agreed to the discounted rate.
- Discounts on vision materials may not be applicable to certain manufacturers' products.
- The Plan reserves the right to make changes to the products on each tier and to the member’s out-of-pocket costs. Fixed tier pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.
- Services and amounts listed above are subject to change at any time.
- Discounts are not insured benefits.

Section 7 Claims Filing and Disputed Claims Processes

How to File Claims

Participating EyeMed providers will file the claim for you. Discounts are available only at in- network providers and are applied at the time of purchase. You are required to pay the discounted amounts to the provider at the time of service.

You are expected to pay the provider in full for treatment from an out-of-network provider. To obtain reimbursement from EyeMed you must file an out-of-network claim with EyeMed using a claim form obtained either by calling EyeMed at (877) 808-8538 or online at www.EyeMed.com. Itemized bills or receipts should be attached to the claim form. Send vision claims to:

EyeMed Vision Care LLC Attn: OON Claims
P.O. Box 8054
Mason, OH 45040-7111

If you need help in filing your claim, call EyeMed toll-free at (877) 808-8538.

Deadline for Filing Your Claim

Claims should be filed within 365 days from the date the expense for which claim is being made was incurred to include submission of all claim corrections within the 365 day claim filing period, unless timely filing was prevented by legal incapacity, provided the claim was submitted as soon as reasonably possible. EyeMed will not accept a claim submitted later than one year from the date of service, except when the member was legally incapable.

Notification of a Claim Decision

You will be notified of the decision on your claim within a reasonable period of time, but no later than 30 days after receipt of your claim. If an extension of time is necessary due to matters beyond EyeMed's control, they may extend this 30-day period by up to 15 days. If this happens, EyeMed will notify you of the extension before the end of the initial 30-day period. The notice will include a description of the matters beyond the Plan's control that justify the extension and the date by which a decision is expected.

If an extension is due to your failure to submit the information needed to decide the claim, the notice of extension will specifically describe the required information. You will then be given at least 45 days from your receipt of the notice to provide that information. The Vision Plan's deadline for deciding your claim shall be suspended from the date you receive the extension notice until the date the missing necessary information is provided to the Plan. If you supply the requested information, the Plan shall decide the claim within the extended period specified in the extension notice. However, if the requested information is not provided within the time specified, the claim may be decided without that information.

Notification of a Claim Denial

In the event a claim is denied, in whole or in part, or if EyeMed takes another final action, the Covered Person will be advised of the following:

- The specific reason for the denial;
- Any additional material or information needed for further review of the claim, along with an explanation of why that material or information is needed;
- An explanation of the review procedure, including the time limits applicable to such review; and,
- A statement of your right to bring a civil action under ERISA, Section 502(a), if applicable.

If EyeMed relied on an internal rule, guideline, protocol or other similar criterion in denying your claim, the notice you receive will include either the specific rule, guideline, protocol or other similar criterion relied upon, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon your request.

Disputed Claims Process

If a claim is denied, in whole or in part, or if you desire to have another final action reviewed you, or an authorized representative acting on your behalf, shall have the right to request EyeMed review the benefit denial or other action. In connection with any review, you will have the opportunity to submit written comments, documents, records and other information relating to your claim. You will also have reasonable access, upon request and free of charge, to all documents, records and other information relevant to your claim. You may also obtain copies of those documents, records and other information. To request a reconsideration of a claim denial or other action, you, or an authorized representative acting on your behalf, must file a written request for reconsideration with EyeMed postmarked within one hundred and eighty (180) days after the date on which you received written notice of the denial or other final action. Failure to comply with this important deadline will cause you to forfeit any right to any further review of a denial of benefits under these procedures or in a court of law. The request must be in writing and include the member's name and ID number, the patient's name and date of birth, a phone number at which to contact you, the provider's name and address, date of service as well as the reason for the request, a copy of the initial determination and any supporting documentation. Requests for reconsideration should be sent to:

EyeMed Vision Care LLC Attention Quality Assurance
4000 Luxottica Place
Mason, OH 45040

If you do have a claim denied, you are urged to carefully review the plan document to ensure that you follow all procedures necessary to perfect any appeal that you must make. In any instance, the plan administrators will revise these procedures as necessary to follow federal law and claim and appeal regulations under Section 503 of the Employee Retirement Income Security Act of 1974 (ERISA).

The request for reconsideration will be treated as received by EyeMed on the date it is hand- delivered to the above address and room; or (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly-stamped envelope containing the above name and address. The postmark on any such envelope will be proof of the date of mailing.

Within sixty (60) days after receipt of your request for reconsideration, the review will be made. Someone other than the person who processed or reviewed the original claim will review your request for reconsideration and will give no deference to the initial benefit decision. The reconsideration will take into account all information submitted by you, regardless of whether or not the information was available or presented at the initial benefit decision.

If the denial was based, in whole or in part, on any medical judgment, EyeMed will consult with a health care professional having appropriate training and experience in the field of ophthalmology involved in the judgment. This health care professional will be different from any individual consulted in connection with the original claim decision and will not be a subordinate of any such individual. If EyeMed obtained advice from any medical experts in making a decision on your claim, those experts will be identified during the course of your appeal, regardless of whether that advice was relied upon in denying your claim.

The EyeMed review decision will be forwarded to you in writing and will include specific reasons for the decision, references to provisions upon which the decision was based, and a statement of your right to file suit in court to obtain payment of your claim for benefits.

If EyeMed relied on an internal rule, guideline, protocol or other similar criterion in denying your request for reconsideration, the notice you receive will include either the specific rule, guideline, protocol or other similar criterion relied upon, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon your request. Similarly, if your request for reconsideration was denied on the basis of medical necessity or an experimental treatment or similar exclusion or limit, the notice will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of The Vision Plan to your circumstances, or a statement that such an explanation will be provided to you free of charge upon your request.

You shall, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. If the advice of a medical or vocational expert was obtained, the names of such experts will be provided to you upon request, regardless of whether the advice was relied on by the Plan.

Standard of Review

The decision of EyeMed will be final and binding and will only be subject to review if such decision was arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of EyeMed shall be based only on such evidence presented to or considered by EyeMed at the time it made the decision that is now subject to review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decision that EyeMed makes, in its sole discretion, and further, constitutes agreement to the limited scope of review described in this Section.

Exhaustion of Remedies

No action at law or in equity can be brought to recover from The Vision Plan until the review procedure has been exhausted as described above

Section 8 Definitions of Terms We Use in This Brochure

Benefits

Covered services or payment for covered services to which enrollees and covered family members are entitled to the extent provided by this brochure.

Calendar Year

The period of time that starts January 1 and ends December 31 of each year. For any Covered Person who first becomes covered after January 1 of any year, a Calendar Year shall be deemed to be the continuous period of time between the date coverage became effective and December 31 of that year.

Child

Child includes only:

- Your natural child or adopted child; and
- Your stepchild, grandchild or other child who lives with you in a regular parent-child relationship and for whom you (or your spouse who lives with you) have custody.

Copay

Copay is the stated amount you must pay for insured covered services from an EyeMed participating provider.

Copayment

A copayment is a fixed amount of money you pay to the provider when you receive services.

Covered Person

A Covered Person means a Member or Eligible Dependent who is covered by any of the following plans:

- G.E.H.A Federal Employee Health Benefit (FEHB) Plan members –
  - High Option
  - Standard Option
  - Elevate
  - Elevate Plus
- G.E.H.A Postal Service Health Benefit (PSHB) Plan members –
  - High Option
  - Standard Option
- G.E.H.A Federal Employee Dental and Vision Insurance Program (FEDVIP) members –
  - High Option
  - Standard Option
- G.E.H.A Connection Dental Plus members

Covered Provider

A covered provider is any licensed optometrist, ophthalmologist, or optician acting within the scope of such license.

Covered Service

A Covered Service is limited to one routine vision exam per Covered Person per Calendar Year. A Covered Service must be incurred and completed while the person receiving the service is a Covered Person. Covered Services are subject to plan provisions for exclusions and limitations as determined by EyeMed or the underwriter of the plan, Fidelity Security Life Insurance Company®.

Debarred

Services or treatment performed by debarred providers.

Eligible Dependent

An Eligible Dependent is:

- Your legally married spouse; and
- Each Child who is determined eligible as defined by the G.E.H.A plan of which you are a member.

Eligible Person

An Eligible Person is:

- Any federal employee or annuitant who is enrolled in High Option or Standard Option of the G.E.H.A health plan under the Federal Employees Health Benefits Program (FEHB); or
- Any federal employee or annuitant who is enrolled in Elevate or Elevate Plus of the G.E.H.A health plan under the Federal Employees Health Benefits Program

(FEHB); or
- Any federal employee or annuitant who is enrolled in High Option, Standard Option of the G.E.H.A health plan under the Postal Service Health Benefits Program (PSHB); or
- Any federal employee or annuitant who is enrolled in the G.E.H.A Connection Dental Plus Plan; or
- Any federal employee or annuitant who is enrolled in High Option or Standard Option of the G.E.H.A Connection Dental Federal Plan under the Federal Employees Dental and Vision Insurance Program (FEDVIP)

Notwithstanding the above, an Eligible Person does not include a Member who has been enrolled in other vision coverage through the G.E.H.A Medicare Advantage Plan or a High Deductible Health Plan.

Enrollee The Federal employee, annuitant, or TRICARE-eligible individual enrolled in this plan.

Enrollment Period The Enrollment Period is the time period that begins with you or your Dependent(s)' Eligibility Date and ends when you are no longer an Eligible Person.

FEDVIP Federal Employees Dental and Vision Insurance Program.

FEHB Federal Employe Health Benefit.

G.E.H.A Government Employees Health Association, Inc.

Incur/Incurred A Covered Service is deemed Incurred on the date care, treatment or service is received.

Maximum Benefit Limits Benefits are limited to one routine vision exam per person and/or limited eyewear materials per Calendar Year. The Maximum Benefit applies to a Covered Person even if that Covered Person's coverage has been interrupted or if that Covered Person has been covered both as a Member and as a Dependent or is covered by more than one eligible G.E.H.A Plan. Maximum Benefit Limits apply separately to each Covered Person. See the Benefit Schedule for a description of how benefits are paid.

Non-participating Provider Non-participating Provider means an Optical Provider who does not participate in the EyeMed network.

Optical Practitioner Any licensed optometrist, ophthalmologist or optician acting within the scope of such license.

Participating Provider Participating Provider means an Optical Provider who participates in an EyeMed network. For a list of participating locations access your G.E.H.A web account, geha.com/vision, or call 877-808-8538.

Plan Allowance The amount we use to determine our payment for out-of-network services.

Plan End Date December 31st

Plan Renewal Date January 1st

Pre-Determination This is the procedure used by the plan to estimate covered services and the amount that the plan will cover. It is not a guarantee of payment.

PSHB Postal Service Health Benefit

Service Date The specific date when the Member was provided medical care or treatment by a healthcare practitioner.

We/Us Government Employees Health Association, Inc.

You G.E.H.A Connection Vision enrollee or eligible family member.

Section 9 Continuation of Coverage

The right to COBRA Continuation of Coverage was created by a federal law called the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your Vision Plan coverage. It can also become available to Eligible Dependents who are covered under the Plan when they would otherwise lose their Vision Plan coverage.

COBRA Continuation of Coverage is a continuation of The Vision Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA Continuation of Coverage must be offered to each person who is a "qualified beneficiary". You and your Eligible Dependents could become qualified beneficiaries if coverage under The Vision Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage under an eligible G.E.H.A Heath Plan, G.E.H.A Connection Dental Federal Plan, or G.E.H.A Connection Dental Plus Plan. automatically receive COBRA Continuation of Coverage under The Vision Plan for no additional COBRA premiums.
If COBRA continuation is elected, coverage will continue as though the qualifying event had not occurred. Any benefits paid prior to the qualifying event will be retained. If any changes are made to the coverage for the Member, the coverage provided to Covered Persons under this continuation provision will be similarly changed.

Qualifying Events

Continuation is available to Covered Persons in the event of the following Qualifying Event:

- A Member is no longer an Eligible Person, unless such loss of eligibility is due to gross misconduct.

Continuation shall also be available to a covered Eligible Dependent in the event of any one of the following Qualifying Events:

- A Member's death;
- Member is no longer an Eligible Person, unless such loss of eligibility is due to gross misconduct;
- Divorce or legal separation from a Member. If a member reduces or eliminates coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for the Eligible Dependent spouse even though his or her coverage was reduced or eliminated before the divorce or separation;
- A Dependent Child ceasing to qualify as a Dependent Child; and
- A Member's entitlement to Medicare.

If You Do Not Elect COBRA Continuation of Coverage Under Another Eligible G.E.H.A. Plan and You Want to Elect COBRA Continuation of Coverage Under The Vision Plan, You Must Give Notice of Qualifying Events

In most instances, as described above, COBRA Continuation of Coverage will be automatically included for no additional COBRA premiums when you elect COBRA Continuation of Coverage under another eligible G.E.H.A. Plan. Otherwise, The Vision Plan will offer COBRA Continuation of Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. You are responsible for notifying The Vision Plan of any qualifying event and to provide The Vision Plan with all information needed to meet its obligation to provide continuing coverage. Your employer or payroll office will not notify The Vision Plan when a Qualifying Event occurs. You must provide this notice to G.E.H.A within 60 days after the qualifying event occurs by sending written notice to:

G.E.H.A Connection Vision COBRA Notification
P.O. Box 6707
Lee's Summit, MO 64064

How COBRA Coverage is provided

Once G.E.H.A receives notice from you that a qualifying event has occurred, COBRA Continuation of Coverage will be offered to each qualified beneficiary at no charge. Each qualified beneficiary will have an independent right to elect COBRA Continuation of Coverage. Covered Members may elect COBRA Continuation of

Coverage on behalf of their Eligible Dependents.

Period of Continuation Coverage for Member

A Member who qualifies for COBRA Continuation of Coverage because he or she is no longer an Eligible Person may elect COBRA Continuation of Coverage for up to eighteen (18) months measured from the date of the Qualifying Event.

Period of Continuation Coverage for Covered Eligible Dependents

If a Covered Eligible Dependent elects COBRA Continuation of Coverage because the Member is no longer an Eligible Person, coverage may be continued for up to eighteen (18) months measured from the date of the Qualifying Event. Coverage may be continued for all other Qualifying Events for up to thirty-six (36) months.

Extension of COBRA Continuation Period for Disabled Members

The period of continuation shall be extended to twenty-nine (29) months in total (measured from the date of the Qualifying Event) in the event the Member is disabled (as determined by the Social Security Administration) within sixty (60) days after the date of the Qualifying Event.

The disability extension is available only if the Member notifies The Vision Plan in writing of the Social Security Administration's determination of disability within 60 days after the latest of: (1) the date of the Social Security Administration's disability determination; or (2) the date of the Qualifying Event. In addition, notice must be provided prior to the expiration of the initial eighteen (18) months of continuation coverage. If a second Qualifying Event occurs during the eleven (11) month disability extension explained herein, coverage may be continued for a maximum of thirty-six (36) months from the date of the first Qualifying Event. The second Qualifying Event must be a Qualifying Event that entitles continuation for thirty-six (36) months. In such event, we may charge the Covered Person up to 150% of the cost of the coverage for all months after the eighteenth (18th) month of continuation coverage, if (1) continuation coverage would not be available in the absence of a disability extension, and (2) the disabled qualified beneficiary is included in the coverage.

Extension of COBRA Continuation Period for Disabled Dependents

The period of continuation shall be extended to twenty-nine (29) months in total (measured from the date of the Qualifying Event) in the event the Eligible Dependent is disabled (as determined by the Social Security Administration) within sixty (60) days after the date of the Qualifying Event. The disability extension is available only if the individual notifies The Vision Plan in writing of the Social Security Administration's determination of disability within 60 days after the latest of: (1) the date of the Social Security Administration's disability determination; (2) the date of the Qualifying Event; and (3) the date on which the qualified beneficiary loses or would lose coverage under the terms of the Plan as a result of the Qualifying Event. In addition, notice must be provided prior to the expiration of the initial eighteen (18) months of continuation coverage.

Subsequent Qualifying Event

If a second Qualifying Event occurs during an eighteen (18) month period of COBRA Continuation of Coverage explained above, a Dependent's coverage may be continued for a maximum of thirty-six (36) months from the date of the first Qualifying Event. The second Qualifying Event must be a Qualifying Event that entitles continuation for thirty-six (36) months. In the event the Dependent loses coverage due to a Qualifying Event, and the Member then becomes entitled to Medicare, the Eligible Dependent shall have available up to thirty-six (36) months of coverage measured from the date of the Qualifying Event that causes the loss of coverage. If the Member was entitled to Medicare prior to the Qualifying Event, the Eligible Dependent shall have up to thirty-six (36) months of coverage measured from the date of entitlement to Medicare.

Electing COBRA Continuation of Coverage

The Covered Person must elect COBRA continuation coverage within sixty (60) days from the date of loss of coverage as a result of a Qualifying Event or sixty (60) days from the date another eligible G.E.H.A. Plan mails or otherwise provides the Covered

Person with notification of the Covered Person's right pursuant to a Qualifying Event to elect coverage.

Premiums for Continuation

The Premium payment for COBRA Continuation of Coverage under the applicable G.E.H.A. medical or dental plan in which you were enrolled shall be a monthly payment unless the qualified beneficiary chooses to pay the entire premium in advance. There is no additional COBRA premium for coverage under the Vision Plan other than the applicable COBRA rate under the G.E.H.A medical or dental plan in which you were enrolled. The qualified beneficiary pays Premiums by check. Payment of the initial Premium is not required until the forty-fifth (45th) day after the election.

Newborn Child or Child Placed for Adoption during Period of Continuation of Coverage

If the Member elects COBRA Continuation of Coverage and, during the period of continuation coverage, a child is born to or placed for adoption with the Member, the Member has the right to elect COBRA Continuation of Coverage for the child, provided the child satisfies the otherwise applicable Dependent Eligibility requirements and the member notifies us of the birth or placement for adoption, within thirty (30) days of the birth or placement. The period of COBRA Continuation of Coverage shall be the same as that for the Member, or as set forth below.

Open Enrollment Rights

Qualified Beneficiaries who have elected COBRA Continuation of Coverage will be given the same opportunity to change their coverage option or add or drop Dependents at open enrollment as similarly situated active employees.

Termination of COBRA Continuation of Coverage

COBRA Continuation of Coverage shall not be provided beyond whichever of the following dates is first to occur:

- The date The Vision Plan is terminated.
- The last day of the month for which the Covered Person has made the required Premium payment to continue coverage under an eligible G.E.H.A. medical or dental plan.
- The date the qualified beneficiary becomes entitled to Medicare (this applies only to Qualified Beneficiaries who become entitled to Medicare after electing COBRA continuation coverage).
- The first day of the month beginning more than thirty (30) days after the Social Security Administration determines that a qualified beneficiary, entitled to twenty-nine (29) months of coverage on account of disability, is no longer disabled.
- The date on which we terminate the qualified beneficiary's coverage for cause, for a reason other than the continuation coverage requirements of federal law.

USERRA Coverage

Rights under COBRA and USERRA are similar but not identical. Any election made pursuant to COBRA will also be an election under USERRA. COBRA and USERRA will both apply with respect to the Continuation of Coverage elected. If COBRA or USERRA provides Members and covered Dependents different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures for COBRA also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") established requirements that employers must meet for certain employees who are involved in the Uniformed Services. In addition to the rights under COBRA, employees who are involved in the Uniformed Services are entitled to rights under USERRA to continue coverage under The Vision Plan.

Uniformed Services means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full time National Guard duty pursuant to orders issued under federal law, and the commissioned corps of the Public Health Service and any other category of persons designated by the President in time of war or national emergency.

Service in the Uniformed Services or Service means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty, the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain duty and training by intermittent disaster response personnel of the National Disaster Medical System.

Period of Absence	Return to Work Requirement
Less than 31 days	Report to work at the beginning of the first regularly scheduled work period following the end of service plus 8 hours, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the employee.
More than 30 days but less than 181 days	Submit an application for employment not later than 14 days after the completion of the service, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the employee.
More than 180 days	Submit an application for employment not later than 90 days after the completion of the service.
Any period, if the absence was for purposes of an examination for fitness to perform service.	Report to work at the beginning of the first regularly scheduled work period following the end of service plus 8 hours, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the employee.
Any period, if you were hospitalized for or are convalescing from an Injury or Illness incurred or aggravated as a result of your service.	Apply for work or submit application as described above (depending on length of absence) when recovery is over, but recovery time is limited to two years. The 2-year period is extended by any minimum time required to accommodate circumstances beyond the employee's control that make compliance with these deadlines unreasonable or impossible.

Duration of Coverage

When a Member takes a leave for service in the Uniformed Services, USERRA coverage for the Member (and covered Dependents for whom coverage is elected) begins the day after the Member (and covered Dependents) lose coverage under The Vision Plan, and it may continue for up to 24 months. However, USERRA coverage will end earlier if one of the following events takes place: (a) A premium payment is not made within the required time; (b) Failure to return to work within the timeframe required under USERRA (see below) following the completion of service in the Uniformed Services; or (3) Rights under USERRA terminate as result of a dishonorable discharge or other conduct specified in USERRA.

Rights under USERRA will terminate if an employee fails to notify his or her employer of his or her intent to return to work within the timeframe provided under USERRA following the completion of services in the Uniformed Services by either reporting to work (when the absence was for less than 31 days) or applying for reemployment (if the absence was for more than 30 days). The time for returning to work depends on the length of the absence, as follows:

COBRA coverage and USERRA coverage begin at the same time and run concurrently. However, COBRA coverage can continue longer, depending on the qualifying event, and is subject to different early termination provisions. In contrast, USERRA coverage can continue for up to 24 months, as described earlier in this Article.

Premiums under USERRA

If a Member elects to continue coverage pursuant to USERRA, the Member will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if a Members Uniformed Service leave of absence is less than 31 days, the Member is not required to pay more than the amount paid as an active employee for the same coverage.