# UnitedHealthcare Vision

# UnitedHealthcare Insurance Company of New York

# Certificate of Coverage

**For**

**the Plan V1007**

**of**

**Friends Academy**

**Group Number: 716374**

**Effective Date: July 1, 2023**

# Certificate of Coverage

# UnitedHealthcare Insurance Company of New York

## What Is the Certificate of Coverage?

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company of New York and the Group. The *Certificate* describes Covered Vision Care Services, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Group's *Application* and payment of the required Policy Charges.

In addition to this *Certificate*, the Policy includes:

- The *Schedule of Covered Vision Care Services*.
- The Group's *Application*.
- Riders.
- Amendments.

You can review the Policy at the Group's office during regular business hours.

## Can This Certificate Change?

We may, from time to time, change this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When this happens we will send you a new *Certificate*, Rider or Amendment.

## Other Information You Should Have

We have the right to change, interpret, withdraw or add Benefits, or to end the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date shown in the Policy. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to *Section 4: When Coverage Ends*.

We are delivering the Policy in New York. The Policy is governed by ERISA unless the Group is not an employee health and welfare plan as defined by ERISA. To the extent that state law applies, New York law governs the Policy.

# Introduction to Your Certificate

This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

## What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company of New York. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

## How Do You Use This Document?

Read your entire *Certificate* and any attached Riders and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *Certificate* and *Schedule of Covered Vision Care Services* and any attachments in a safe place for your future reference.

Review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Covered Vision Care Services* along with *Section 1: Covered Vision Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 7: General Legal Provisions* to understand how this *Certificate* and your Benefits work. Call us if you have questions about the limits of the coverage available to you.

If there is a conflict between this *Certificate* and any summaries provided to you by the Group, this *Certificate* controls.

Please be aware that your Vision Provider is not responsible for knowing or communicating your Benefits.

## How Do You Contact Us?

Call us at 1-800-638-3120. Throughout the document you will find statements that encourage you to contact us for more information.

# Your Responsibilities

## Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Policy issued to your Group, including the eligibility requirements.
- You must qualify as a Subscriber or a Dependent as those terms are defined in *Section 8: Defined Terms*.

Your Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy. If you have questions about this, contact your Group.

## Be Aware the Policy Does Not Pay for All Vision Care Services

The Policy does not pay for all vision care services. Benefits are limited to Covered Vision Care Services. The *Schedule of Covered Vision Care Services* will tell you the portion you must pay for Covered Vision Care Services.

## Decide What Services You Should Receive

Care decisions are between you and your Vision Provider. We do not make decisions about the kind of care you should or should not receive.

## Choose Your Vision Provider

It is your responsibility to select the vision care professionals who will deliver your care. We arrange for Vision Providers and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners that are solely responsible for the care they deliver.

## Pay Your Share

You must meet any applicable Deductible and pay a Co-payment and/or Co-insurance for most Covered Vision Care Services. These payments are due at the time of service or when billed by the Vision Provider. Any applicable Deductible, Co-payment and Co-insurance amounts are listed in the *Schedule of Covered Vision Care Services*. You must also pay any amount that exceeds your Benefits.

## Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with the Policy's exclusions.

## File Claims with Complete and Accurate Information

When you receive Covered Vision Care Services from an out-of-Network Vision Provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

# Our Responsibilities

## Determine Benefits

We make administrative decisions regarding whether the Policy will pay for any portion of the cost of a vision care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive.

We have the final authority to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Covered Vision Care Services* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may assign this authority to other persons or entities that may provide administrative services for the Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time as we determine. In order to receive Benefits, you must cooperate with those service providers.

## Pay for Our Portion of the Cost of Covered Vision Care Services

We pay Benefits for Covered Vision Care Services as described in *Section 1: Covered Vision Care Services* and in the *Schedule of Vision Care Services*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Vision Care Services. It also means that not all of the vision care services you receive may be paid for (in full or in part) by the Policy.

## Pay Network Providers

It is the responsibility of Network Vision Providers and facilities to file for payment from us. When you receive Covered Vision Care Services from Network providers, you do not have to submit a claim to us.

## Pay for Covered Vision Care Services Provided by Out-of-Network Providers

In accordance with any state prompt pay requirements, we pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*. Your cost sharing may be more when you see an out-of-Network Vision Provider.

# Certificate of Coverage Table of Contents

**Section 1: Covered Vision Care Services.....7**
**Section 2: Exclusions and Limitations.....10**
**Section 3: When Coverage Begins .....11**
**Section 4: When Coverage Ends .....14**
**Section 5: How to File a Claim .....16**
**Section 6: Questions, Complaints and Appeals .....18**
**Section 7: General Legal Provisions .....20**
**Section 8: Defined Terms .....25**

# Section 1: Covered Vision Care Services

## When Are Benefits Available for Covered Vision Care Services?

Benefits are available only when all of the following are true:

- The vision care service, including materials as shown in the *Schedule of Covered Vision Care Services*.
- You receive Covered Vision Care Services while the Policy is in effect.
- You receive Covered Vision Care Services prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Vision Care Services is a Covered Person and meets all eligibility requirements specified in the Policy.

This section describes Covered Vision Care Services for which Benefits are available. Please refer to the attached *Schedule of Covered Vision Care Services* for details about:

- The amount you must pay for these Covered Vision Care Services (including any Co-payment).
- Any limit that applies to these Covered Vision Care Services (including frequency and dollar limits on services and materials).

### 1. Routine Vision Examination

A routine vision exam of the eyes and according to the standards of care in your area, including:

A. A patient history that includes reasons for the exam, patient medical/eye history, and current medications;

B. Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40);

C. Cover test at 20 feet and 16 inches (checks how the eyes work together as a team);

D. Ocular motility (how the eyes move) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D Vision);

E. Pupil reaction to light and focusing;

F. Exam of the eye lids, lashes, and outside of the eye;

G. Refraction (when applicable) - to determine power of corrective lenses for distance and near vision; Retinoscopy (when applicable): Objective refraction to determine lens power of corrective lenses. Subjective refraction to determine lens power of corrective lenses;

H. Photometry/Binocular testing - far and near: how well eyes work as a team;

I. Tonometry, when indicated: test pressure in eye (glaucoma check);

J. Ophthalmoscopic exam of the internal eye;

K. Visual field testing;

L. Biomicroscopy;

M. Color vision testing;

N. Diagnosis/prognosis;

O. Dilation (when indicated) - Examine the internal structures of the eye; and

P. Specific recommendations.

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

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

## 2. Eyeglass Lenses

Lenses that are mounted in an eyeglass frame and worn on the face to correct visual acuity limitations.

## 3. Eyeglass Frame

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

## 4. Optional Lens Extras

Special lens stock or modifications to lenses that do not correct visual acuity problems. Optional Lens Extras include options such as, but not limited to, lens tints, polycarbonate lenses, high-index lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photochromic.

## 5. Contact Lenses

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

## 6. Necessary Contact Lenses

This benefit is available where a Vision Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Provider and not by us.

Contact lenses are necessary if the Covered Person has:

A. Keratoconus;

B. Anisometropia;

C. Irregular corneal/astigmatism;

D. Aphakia;

E. Facial deformity;

F. Corneal deformity;

G. Pathological myopia;

H. Aniseikonia;

I. Aniridia;

J. Post-traumatic disorders;

K. Post-cataract surgery without intraocular lens; or

L. Visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses.

## 7. Contact Lens Fitting & Evaluation

A contact lens evaluation and fitting includes examination and measurement of the eyes and adjacent structures to determine the contact lens size, design and power to achieve and maintain eye health, comfort and vision.

## 8. Virtual Visits

Virtual visits for Covered Vision Care Services through live audio and video technology. Virtual visits provide a Routine Vision Examination for the patient by a distant Vision Provider.

Network Benefits are available only when services are delivered through a Designated Virtual Network Vision Provider. You can find a Designated Virtual Network Vision Provider by contacting us at www.myuhcvision.com or by calling us at 1-800-638-3120.

**Please Note**: Not all Routine Examinations or other services can be provided through virtual visits. The Designated Virtual Network Vision Provider will identify any patients for which services by in-person Vision Provider is needed.

Benefits do not include email, fax and standard telephone calls.

# Section 2: Exclusions and Limitations

## We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, and materials described in this section, even if it is recommended or prescribed by a Physician or Vision Provider.

The services, treatments, and materials listed in this section are not Covered Vision Care Services, except as may be specifically provided for in *Section 1: Covered Vision Care Services* or through a Rider to the Policy.

## Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Vision Care Service categories described in *Section 1: Covered Vision Care Services*, those limits are stated in the corresponding Covered Vision Care Service category in the *Schedule of Covered Vision Care Services*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

The following Services and materials are excluded from coverage under the Policy:

A. Non-prescription items (e.g. Plano lenses) other than those listed in the *Schedule(s) of Covered Vision Care Services*.

B. Services that the Covered Person, without cost, obtains from any governmental organization or program.

C. Services for which the Covered Person is proved compensated under Workers' Compensation Law, or other similar employer liability law.

D. Medical or surgical treatment for eye disease, which requires the services of a Physician.

E. Replacement or repair of lenses and/or frame that have been lost or broken.

F. Optional Lens Extras not listed in the *Schedule of Covered Vision Care Services*.

G. Technological devices such as smart phones and tablets used as Optical Low Vision Aids.

H. Missed appointment charges.

I. Applicable sales tax charged on Services.

J. Services that are not specifically covered by the Policy.

K. Procedures that are considered to be Experimental, Investigational or Unproven. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

L. Any Vision Service rendered by the Policyholder.

M. Intraocular lenses.

# Section 3: When Coverage Begins

## How Do You Enroll?

Eligible Persons must complete an enrollment form given to them by the Group. The Group will submit the completed forms to us, along with any required Premium. We will not provide Benefits for vision care services that you receive before your effective date of coverage.

## Who Is Eligible for Coverage?

The Group determines who is eligible to enroll and who qualifies as a Dependent.

### Eligible Person

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Group and Subscriber, see *Section 8: Defined Terms*.

If both spouses are Eligible Persons of the Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

### Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

## When Do You Enroll and When Does Coverage Begin?

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

### Initial Enrollment Period

When the Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Policy. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

### Open Enrollment Period

The Group sets the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible.

## New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Group. We must receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

## Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.

All vision benefits applicable for children, including the Necessary care or treatment of medically diagnosed congenital defects or birth abnormalities, will apply with respect to your newborn child from the moment of birth.

- Legal adoption and Placement for adoption.

All vision benefits applicable to children will apply to your adopted child, including a newborn child, from the moment of placement in your residence.

In the case of a newborn child, coverage begins at the moment of birth if you have entered into a written agreement to adopt such child.

- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

Coverage for the Dependent begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event.

## Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing vision coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including legal separation, divorce or death).
    - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
    - In the case of COBRA continuation coverage, the coverage ended.
    - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
    - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. We must receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

# Section 4: When Coverage Ends

## General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Your right to Benefits automatically ends on the date that coverage ends. When your coverage ends, we will still pay claims for Covered Vision Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any vision care services received after that date.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

## What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below, with a 30 day notice:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends. In this event, the Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 8: Defined Terms* for definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends on the date we receive the required notice from the Group to end your coverage, or on the date requested in the notice, if later.

- **Subscriber Retires or Is Pensioned**

  The Group is responsible for providing the required notice to us to end your coverage. Your coverage ends the date the Subscriber is retired or receiving benefits under the Group's pension or retirement plan.

  This provision applies unless there is specific coverage classification for retired or pensioned persons in the Group's *Application*, and only if the Subscriber continues to meet any applicable eligibility requirements. The Group can provide you with specific information about what coverage is available for retirees.

## Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 30 days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

## Coverage for a Disabled Dependent Child

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or Covered Subscriber and all other prospective or Covered Members as they pertain to eligibility for coverage under this Policy at any time.

## Continuation of Coverage

If your coverage ends under the Policy, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under *COBRA* (the federal *Consolidated Omnibus Budget Reconciliation Act*) is available only to Groups that are subject to the terms of *COBRA*. Contact your plan administrator to find out if your Group is subject to the provisions of *COBRA*.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

# Section 5: How to File a Claim

## How Are Covered Vision Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Vision Care Services. If a Network provider bills you for any Covered Vision Care Service, contact us. However, you are required to meet any applicable Deductible and to pay any required Co-payments and/or Co-insurance to a Network provider. You will also be responsible for any charges that are not covered by the Policy to your Vision Provider.

## How Are Covered Vision Care Services from an Out-of-Network Provider Paid?

When you receive Covered Vision Care Services from an out-of-Network provider you will be required to pay all billed charges to your Vision Provider. You are also responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that vision care service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated.

### Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- Your identification number.
- The name and address of the provider of the service(s).
- An itemized bill from your provider that includes a description of each charge.

The above information should be filed with us at Claims Department, PO Box 30978, Salt Lake City, UT 84130 or by fax to 248-733-6060. If you would like to use a claim form, you may access a form on the Internet at www.myuhcvision.com or call us at 1-800-638-3120 and a claim form will be provided to you.

### Payment of Benefits

If you provide written authorization to allow this, all or a portion of Benefits due to a provider may be paid directly to the provider instead of being paid to the Subscriber. We will not reimburse third parties that have purchased or been assigned benefits by Physicians or other Vision Providers.

Benefits will be paid to you unless either of the following is true:

- The Vision Provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

Payment of Benefits under the Policy shall be in cash or cash equivalents, or in a form of other consideration that we determine to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes us,

or to other plans for which we make payments where we have taken an assignment of the other plans' recovery rights for value.

## Obtaining Services

To find a Network Vision Provider, you may access a listing of Network Vision Providers on the Internet at www.myuhcvision.com. You may also call the UnitedHealthcare Provider Locator Service at 1-800-839-3242.

You also may obtain Vision Care Services from an out-of-Network Vision Provider. However, the amount of Benefits may be reduced.

## Foreign Services

Foreign Services will be treated as Out-of-Network Benefits under this Policy. Payments will be made in U.S. currency and dispersed to the U.S. address of the Subscriber. We make no guarantee on value of payment and will not protect against currency risk. Currency valuations for payment liability will be based on exchange rates published on the date the Vision Care Services were rendered.

# Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

## What if You Have a Question?

Contact Customer Service at 1-800-638-3120. Representatives are available to take your call during regular business hours, Monday through Friday.

## What if You Have a Complaint?

Contact Customer Service at 1-800-638-3120. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

## How Do You Appeal a Claim Decision?

### How to Request an Appeal

If you disagree with either claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and Policy number.
- The date(s) of vision service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to us within 180 days after you receive claim denial.

## Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a vision care professional with expertise in the field, who was not involved in the prior determination. We may consult with, or ask vision experts to take part in the appeal process. You consent to this referral and the sharing of needed vision claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

## Appeals Determinations

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of Benefits, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

# Section 7: General Legal Provisions

## What Is Your Relationship with Us?

It is important for you to understand our role with respect to the Group's Policy and how it may affect you. We help finance or administer the Group's Policy in which you are enrolled. We do not provide vision services or make treatment decisions. This means:

- We communicate to you decisions about whether the Group's Policy will cover or pay for the vision care that you may receive. The Policy pays for Covered Vision Care Services, which are more fully described in this *Certificate*.
- The Policy may not pay for all vision services or materials you or your Vision Provider may believe are needed. If the Policy does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

## What Is Our Relationship with Providers and Groups?

The relationships between us and Network Vision Providers and Groups are solely contractual relationships between independent contractors. Network Vision Providers and Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network Vision Providers or the Groups.

We do not provide vision care services or materials. We arrange for vision providers to participate in a Network and we pay Benefits. Network Vision Providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network vision providers such as principal-agent or joint venture. We are not responsible for any act or omission of any vision provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Group's Policy. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Group's Policy.

The Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of when the Policy ends.

When the Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

## What Is Your Relationship with Providers and Groups?

The relationship between you and any vision provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own Vision Provider.
- Paying, directly to your Vision Provider, any amount identified as a member responsibility, including Co-payments, Co-insurance, any Deductible and any amount that exceeds your Benefits.
- Paying, directly to your Vision Provider, the cost of any non-Covered Vision Care Service.
- Deciding if any Vision Provider treating you is right for you. This includes Network Vision Providers you choose and vision providers that they refer.
- Deciding with your Vision Provider what care you should receive.
- Paying all billed charges, directly to your out-of-Network provider.

Your Vision Provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Group is that of employer and employee, Dependent or other classification as defined in the Policy.

## Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Group is responsible for giving notice to you.

## How Do We Use Headings?

The headings, titles and any table of contents contained in the Policy, *Certificate* or *Schedule of Covered Vision Care Services* are for reference purposes only and shall not in any way affect the meaning or interpretation of the Policy, *Certificate* or *Schedule of Covered Vision Care Services*.

## Statements by Group or Subscriber

All statements made by the Group or by a Subscriber shall be deemed representations and not warranties. We will not use any statement made by the Group to void the Policy after it has been in force for two years.

## Who Interprets Benefits and Other Provisions under the Policy?

We have the final authority to do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Covered Vision Care Services* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may assign this authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Vision Care Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

## Who Provides Administrative Services?

We provide administrative services or, as we determine, we may arrange for various persons or entities to provide administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

## Amendments to the Policy

To the extent permitted by law, we have the right, as we determine and without your approval, to change, interpret, withdraw or add Benefits or end the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers and consistent with applicable notice requirements. All of the following conditions apply:

- Amendments and Riders to the Policy are effective upon the Group's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

## How Do We Use Information and Records?

We may use your individually identifiable health information as follows:

- To administer the Policy and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release records concerning vision care services when any of the following apply:

- Needed to put in place and administer the terms of the Policy.
- Needed for review or quality assessment.

- Required by law or regulation.

During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your vision records or billing statements you may contact your Vision Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request vision forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as needed. Our designees have the same rights to this information as we have.

## Do We Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Vision Provider of our choice examine you at our expense.

## Is Workers' Compensation Affected?

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

## When Do We Receive Refunds of Overpayments?

If we pay Benefits for expenses incurred on your account, you, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid or did not legally have to be paid by you.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, you agree to help us get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits that are payable under the Policy. If the refund is due from a person or organization other than you, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

## Is There a Limitation of Action?

You cannot bring any legal action against us to recover reimbursement until sixty days after proof of loss has been filed in accordance with the requirements of the policy. Any legal action against us must be brought prior to the expiration of two years following the time such proof of loss is required.

## What Is the Entire Policy?

The Policy, this *Certificate*, the *Schedule of Covered Vision Care Services*, the Group's *Application* and any Riders and/or Amendments, make up the entire Policy that is issued to the Group.

# Section 8: Defined Terms

**Amendment** - any attached written description of added or changed provisions to the Policy. It is effective only when signed by us. It is subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

**Benefits** - your right to payment for Covered Vision Care Services that are available under the Policy.

**Co-insurance** - the charge, stated as a percentage, that you are required to pay for certain Covered Vision Care Services.

**Co-payment** - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Vision Care Services.

**Covered Contact Lens Formulary** - a selection of available contact lenses that may be obtained from a Network Vision Provider on a covered-in-full basis, subject to payment of any applicable Co-payment.

**Covered Person** - the Subscriber or a Dependent, but this term applies only while the person is enrolled under the Policy. We use "you" and "your" in this *Certificate* to refer to a Covered Person.

**Covered Vision Care Service(s)** - vision care services which we determine to be all of the following:

- Necessary.
- Described as a Covered Vision Care Service in this *Certificate* under *Section 1: Covered Vision Care Services* and in the *Schedule of Covered Vision Care Services*.
- Not excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

**Dependent** - the Subscriber's legal spouse or an unmarried child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in *Section 3: When Coverage Begins*, the Group determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption, including during any waiting period prior to the finalization of the adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- A child for whom vision care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

The following conditions apply:

- A Dependent includes a child listed above under age 26.
- A Dependent includes an unmarried child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the date the child reaches 26.

The Subscriber must reimburse us for any Benefits paid during a time a child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

**Designated Virtual Network Provider** - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Vision Care Services through live audio and video technology.

**Domestic Partner** - Coverage is included for domestic partners, who are financially interdependent on the employee or member.

The applicant must provide the following:

- Registration as a domestic partner or an affidavit of domestic partnership.
- Proof of cohabitation.
- Proof of financial interdependency by evidence of two or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner's bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other's life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners' financial interdependence; other items of sufficient proof to establish economic interdependency under the circumstances of the particular case.

**Eligible Person** - an employee of the Group or other person connected to the Group who meets the eligibility requirements shown in both the Group's *Application* and the Policy.

**Enrolled Dependent** - a Dependent who is properly enrolled under the Policy.

**Experimental or Investigational Service(s)** - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Not demonstrated through prevailing peer-related professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

**Foreign Services** - services provided outside the U.S. and U.S. territories.

**Group** - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

**Initial Enrollment Period** - the first period of time when Eligible Persons may enroll themselves and their Dependents under the Policy.

**Medicare** - Parts A, B, C, and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

**Network** - when used to describe a provider of vision care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Vision Care Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Vision Care Services, but not all Covered Vision Care Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Vision Care Services and products included in the participation agreement and an out-of-Network provider for other Covered Vision Care Services and products. The participation status of providers will change from time to time.

**Network Benefits** - the description of how Benefits are paid for Covered Vision Care Services provided by Network Vision Providers. The *Schedule of Covered Vision Care Services* will tell you if your plan offers Network Benefits and how Network Benefits apply.

**Open Enrollment Period** - a period of time, after the Initial Enrollment Period, when Eligible Persons may enroll themselves and Dependents under the Policy. The Group sets the period of time that is the Open Enrollment Period.

**Out-of-Network Benefits** - the description of how Benefits are paid for Covered Vision Care Services provided by out-of-Network Vision Providers. The *Schedule of Covered Vision Care Services* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

**Physician** - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

**Policy** - the entire agreement issued to the Group that includes all of the following:

- *Group Policy*.
- *Certificate*.
- *Schedule of Covered Vision Care Services*.
- Group *Application*.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Group.

**Policy Charge** - the sum of the Premiums for all Covered Persons enrolled under the Policy.

**Premium** - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

**Rider** - any attached written description of additional Covered Vision Care Services not described in this *Certificate*. Covered Vision Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

**Subscriber** - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Group.

**Vision Provider** - any optometrist, ophthalmologist, surgeon, or other person who may lawfully provide services to Covered Persons participating in our vision plans.

# Schedule of Covered Vision Care Services

The following Vision Care Services will be covered, subject to a Co-payment, when obtained from Network Providers.

When obtaining these Vision Care Services from a Network Provider, you will be required to pay a Co-payment for certain Vision Care Services. The amount of Co-payment that a Network Provider will charge is as noted in the column "Network Benefit" in the chart below.

When obtaining these Vision Care Services from an out-of-Network Provider, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement for out-of-Network Providers will be limited to the amounts noted in the column "Out-of-Network Benefit" in the chart below.

| **SERVICE**[K, M] | **FREQUENCY OF SERVICE** | **NETWORK BENEFIT**<br>**The Amount You Pay** | **OUT-OF-NETWORK BENEFIT**<br>**The Amount You Pay** |
|---|---|---|---|
| Routine Vision Examination for Dependent children up to age 13 | Twice every 12 months | Co-payment of $10 | To a maximum of a $40 allowance |
| Routine Vision Examination for Covered Persons age 13 or older | Once every 12 months | Co-payment of $10 | To a maximum of a $40 allowance |
| Refraction Only in lieu of Routine Vision Examination for Dependent children up to age 13 | Twice every 12 months | To a maximum of a $0 allowance | To a maximum of a $40 allowance |
| Refraction Only in lieu of Routine Vision Examination for Covered Persons age 13 or older | Once every 12 months | To a maximum of a $0 allowance | To a maximum of a $40 allowance |
| **EYEGLASS FRAME**[B1, G] | Once every 24 months | | |
| Eyeglass Frame | | Co-payment of $10[C] to a maximum of a $130 allowance | To a maximum of a $45 allowance |
| **EYEGLASS LENSES**[B1] | Once every 12 months | | |
| Single Vision Lenses* | | Co-payment of $10[C] | To a maximum of a $40 allowance |
| Bifocal-lined Lenses | | Co-payment of $10[C] | To a maximum of a $60 allowance |

| SERVICE[K, M] | FREQUENCY OF SERVICE | NETWORK BENEFIT<br>The Amount You Pay | OUT-OF-NETWORK BENEFIT<br>The Amount You Pay |
|---|---|---|---|
| Trifocal-lined Lenses | | Co-payment of $10[C] | To a maximum of a $80 allowance |
| Lenticular Lenses | | Co-payment of $10[C] | To a maximum of a $80 allowance |
| **OPTIONAL LENS EXTRAS**[F] | Once every 12 months | | |
| Standard Scratch Coating | | Co-payment of $0 | To a maximum of a $0 allowance |
| Oversize Lenses | | 80% of retail billed charge after a Co-payment of $10[C] toward Covered Eyeglass Lenses | To a maximum of a $0 allowance |
| Blended Bifocal Lenses | | 80% of retail billed charge after a Co-payment of $10[C] toward Covered Eyeglass Lenses | To a maximum of a $0 allowance |
| Standard Progressive Lenses | | After a Co-payment of $10[C] toward Covered Eyeglass Lenses and the lesser of $55 or retail billed charge | To a maximum of a $0 allowance |
| Deluxe Progressive Lenses | | After a Co-payment of $10[C] toward Covered Eyeglass Lenses and the lesser of $100 or retail billed charge | To a maximum of a $0 allowance |
| Premium Progressive Lenses | | After a Co-payment of $10[C] toward Covered Eyeglass Lenses and the lesser of $150 or retail billed charge | To a maximum of a $0 allowance |
| Platinum Progressive Lenses | | After a Co-payment of $10[C] toward Covered Eyeglass Lenses and the lesser of $200 or retail billed charge | To a maximum of a $0 allowance |
| Aspheric Lenses | | 80% of retail billed charge after a Co-payment of $10[C] toward Covered Eyeglass Lenses | To a maximum of a $0 allowance |

| SERVICE[K, M] | FREQUENCY OF SERVICE | NETWORK BENEFIT<br>The Amount You Pay | OUT-OF-NETWORK BENEFIT<br>The Amount You Pay |
|---|---|---|---|
| Digital Single Vision Lenses | | 80% of retail billed charge after a Co-payment of $10[C] toward Covered Eyeglass Lenses | To a maximum of a $0 allowance |
| Polycarbonate for Dependent children up to age 19 | | Co-payment of $0 | To a maximum of a $0 allowance |
| Cataract Lenses | | 80% of retail billed charge after a Co-payment of $10[C] toward Covered Eyeglass Lenses | To a maximum of a $0 allowance |
| Occupational Double Segment Lenses | | 80% of retail billed charge after a Co-payment of $10[C] toward Covered Eyeglass Lenses | To a maximum of a $0 allowance |
| **CONTACT LENSES**[B1, H] | Once every 12 months | | |
| Contact Lenses Formulary[J] | | Co-payment of $10 for up to 4 boxes from the Covered Contact Lens Formulary[D]. One Co-payment for Contact Lens Fitting and Evaluation and Contact Lenses combined if from the Covered Contact Lens Formulary[D] to a maximum of a $105 allowance for Contact Lenses that are not on the Formulary[D]. | To a maximum of a $105 allowance |
| Necessary Contact Lenses | | Co-payment of $10 | To a maximum of a $210 allowance |

[B1] You are eligible to select only one of either eyeglasses (Eyeglass Lenses/or Eyeglass Lenses and Eyeglass Frame) or Contact Lenses. If you select more than one of these Vision Care Services, only one service will be covered. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses.

[C] If you purchase Eyeglass Lenses and Eyeglass Frames at the same time from the same Network Provider, only one Co-payment will apply to those Eyeglass Lenses and Eyeglass Frames together.

[D] Coverage for Covered Contact Lens Formulary will not apply at Walmart, Sam's Club, and Costco locations. Other Network locations may not offer Formulary contact lenses. In those cases, your allowance for Contact Lenses that are not on the Formulary will apply.

[F] Coverage for some Optional Lens Extras, which may include progressive lenses, may be included with eyeglass packages offered at some Network locations.

[G] Some eyeglass frame brands may not be available for purchase as a Covered Vision Service, or may be subject to additional limitations.

[H] Necessary contact lenses are in lieu of Contact Lenses.

[J] If Contact Lenses that are not on the Formulary are prescribed; the member will be responsible for the Contact Lens Fitting and Evaluation.

[K] If you choose to use a promotional offer from a provider your claim may be reimbursed based on the out-of-Network coverage.

[M] Additional detail on your plan can be directed to Customer Service 1-800-638-3120.

*Single vision lens are defined as one single power across their entire surface with a single optical center and made from CR-39.

# Language Assistance Services

We[1] provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-800-638-3120, or the toll-free member phone number listed on your vision plan ID card TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-800-638-3120.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：1-800-638-3120。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-800-638-3120.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-638-3120 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-800-638-3120.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является Русский (Russian). Позвоните по номеру 1-800-638-3120.

تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-800-638-3120.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-800-638-3120.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-800-638-3120.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-800-638-3120.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para 1-800-638-3120.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-800-638-3120.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-800-638-3120 an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。1-800-638-3120 にお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. تماس بگیرید 1-800-638-3120

कृपा ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-800-638-3120

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-800-638-3120.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ(Khmer)សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-800-638-3120 ។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-800-638-3120.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-800-638-3120 hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-800-638-3120.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά (Greek), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε 1-800-638-3120.

ધ્યાન આપો: જો તમે ગુજરાતી (Gujarati) બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા
વિના મૂલ્યે પૂરાપૂર્ય છે.
કૃપા કરી 1-800-638-3120 પર કોલ કરો. TTY 711

# Notice of Non-Discrimination

We[1] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-800-638-3120 or the toll-free member phone number listed on your vision plan ID card, TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

[1]For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

# Claims and Appeal Notice

***This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.***

## How to Request an Appeal

If you disagree with a claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and Policy number.
- The date(s) of Vision Service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to us within 180 days after you receive the claim denial.

## Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a Vision care professional with experience in the field, who was not involved in the prior determination. We may consult with, or ask vision experts to take part in the appeal process. You consent to this referral and the sharing of needed vision claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

## Appeals Determinations

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of Benefits, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization* (*IRO*) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

# VISION PLAN NOTICES OF PRIVACY PRACTICES

## MEDICAL INFORMATION PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

Effective January 1, 2019

We[2] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular vision plan, we will post the revised notice on your vision plan website, such as www.myuhcvision.com. We have the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollee information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

### How We Use or Disclose Information

**We must** use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice.
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

**We have the right to** use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may use or disclose health information as needed to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.

- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.

- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

- **For Underwriting Purposes**. We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.

- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

**We may** use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.

- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.

- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.

- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.

- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.

- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as needed to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is needed for such functions or services. Our business associates are required, under contract with us and according to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as shown in our contract as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

    1. Alcohol and Substance Abuse
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors' Information
    9. Prescriptions
    10. Reproductive Health
    11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you,

selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your vision plan ID card.

## What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and get a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice**. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your vision plan website, such as www.myuhcvision.com.

## Exercising Your Rights

- **Contacting your Vision Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your vision ID card or you may call us at 1-800-638-3120, or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

  UnitedHealthcare

  *Vision HIPAA - Privacy Unit*

  PO Box 30978

  Salt Lake City, UT 84130

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

**You may also notify the *Secretary of the U.S. Department of Health and Human Services* of your complaint**. We will not take any action against you for filing a complaint.

[2]*This Vision Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: UnitedHealthcare Insurance Company and UnitedHealthcare Insurance Company of New York. This list of vision plans is complete as of the effective date of this notice. For a current list of vision plans subject to this notice go to www.uhc.com/privacy/entities-fn-v3.*

# FINANCIAL INFORMATION PRIVACY NOTICE

**THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.**

**PLEASE REVIEW IT CAREFULLY.**

*Effective January 1, 2019*

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

**Information We Collect**

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

**Disclosure of Information**

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

**Confidentiality and Security**

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

**Questions about this Notice**

If you have any questions about this notice, please call the toll-free member phone number on your vision plan ID card or call us at 1-800-638-3120, or TTY 711.

[3]*For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Vision Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliate: Spectera, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to any other UnitedHealth Group health plans in states that*

*provide exceptions for HIPAA covered entities or health insurance products. For a current list of vision plans subject to this notice go to www.uhc.com/privacy/entities-fn-v3.*

# Statement of Employee Retirement Income Security Act of 1974 (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)*.

## Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to get, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

## Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan due to a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act* (*COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

## 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, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

## Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get 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 $156 a day (subject to adjustment based on inflation) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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.

## 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 get certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

# ERISA Statement

If the Group is subject to *ERISA*, the following information applies to you.

## Summary Plan Description

**Name of Plan:** Friends Academy Welfare Benefit Plan

**Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:**

Friends Academy
270 Duck Pond Road
Locust Valley, NY 11560
(516) 393-4291

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan, except to the extent the Plan Sponsor has assigned or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

**Claims Fiduciary:** UnitedHealthcare Insurance Company ("UnitedHealthcare," refer to your Certificate of Coverage for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been assigned this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

**Employer Identification Number (EIN):** 11-1633485

**Plan Number:** 501

**Plan Year:** July 1 through June 30

**Type of Plan:** Health care coverage plan

**Name, Business Address, and Business Telephone Number of Plan Administrator:**

Friends Academy
270 Duck Pond Road
Locust Valley, NY 11560
(516) 393-4291

**Type of Administration of the Plan:** Your Plan is fully insured. Benefits are provided under a group insurance contract entered into between your Plan Sponsor and UnitedHealthcare. Claims for benefits are sent to UnitedHealthcare. Your employer and UnitedHealthcare share responsibility for administering the plan.

UnitedHealthcare
2950 Expressway Drive
Suite 240
Islandia, NY 11749-1412
877-832-7734

**Person designated as Agent for Service of Legal Process:** Plan Administrator

**Discretionary Authority of Plan Administrator and Other Plan Fiduciaries:** The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made according to such discretionary authority shall be given deference and be legally binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

**Source of Contributions and Funding under the Plan:** There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

**Method of Calculating the Amount of Contribution:** Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

**Qualified Medical Child Support Orders:** The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

**Amendment or Termination of the Plan:** Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.