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# UNITED HEALTHCARE INSURANCE COMPANY

# VISION INSURANCE

# CERTIFICATE OF COVERAGE

# FOR

# COMPASS SYSTEMS INC.

GROUP NUMBER: GA8X9831NM VISION PLAN: V1048

EFFECTIVE DATE: December 1, 2017

OFFERED AND UNDERWRITTEN BY

UNITED HEALTHCARE INSURANCE COMPANY

# Vision Certificate of Coverage
# UnitedHealthcare Insurance Company

185 Asylum Street
Hartford, CT 06103-3408
1-800-638-3120

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| Issued To: | COMPASS SYSTEMS INC.<br>("Enrolling Group") |
| Policy Number: | GA8X9831NM |
| Policy Effective Date: | December 1, 2017 |

This *Certificate(s) of Coverage ("Certificate")* sets forth your rights and obligations as a Covered Person. It is important that you read your *Certificate* carefully and familiarize yourself with its terms and conditions.

The Policy may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost a Subscriber must pay can be obtained from the Enrolling Group.

UnitedHealthcare Insurance Company (the "Company") agrees with the Enrolling Group to provide Coverage for Vision Services to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued on the basis of the Enrolling Group's application and payment of the required Policy Charges. The Enrolling Group's application is made a part of the Policy.

The Company will not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. The Company will not be responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's benefit plan.

The Policy will take effect on the date specified in the Policy and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of the Policy as provided. All Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight at the Enrolling Group's address.

The Policy is delivered in and governed by the laws of the State of Maryland .

# Introduction to Your Certificate

You and any of your Enrolled Dependents, are eligible for Coverage under the Policy if the required Premiums have been paid. The Policy is referred to in this *Certificate* as the "Policy".

Coverage is subject to the terms, conditions, exclusions, and limitations of the Policy. As a *Certificate,* this document describes the provisions of Coverage under the Policy but does not constitute the Policy. You may examine the entire Policy at the office of the Enrolling Group during regular business hours.

For Vision Services rendered after the effective date of the Policy, this *Certificate* replaces and supersedes any *Certificate* which may have been previously issued to you by the Company that pertains to the specific Vision Services Covered by the Policy.

The employer expects to continue the group plan indefinitely. But the employer reserves the right to change or end it at any time. This would change or end the terms of the Policy in effect at that time for active employees.

## How To Use This Certificate

This *Certificate* should be read in its entirety. Many of the provisions of this *Certificate* and the attached *Schedule(s) of Covered Vision Services* are interrelated; therefore, reading just one or two provisions may not give you an accurate understanding of your Coverage.

Your *Certificate* and *Schedule(s) of Covered Vision Services* may be modified by the attachment of Riders and/or Amendments. Please read the provision described in these documents to determine the way in which provisions in this *Certificate* or *Schedule(s) of Covered Vision Services* may have been changed.

Many words used in this *Certificate* and *Schedule(s) of Covered Vision Services* have special meanings. These words will appear capitalized and are defined for you in *Section 1: Definitions.* By reviewing these definitions, you will have a clearer understanding of your *Certificate* and *Schedule(s) of Covered Vision Services.*

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in *Section 1: Definitions.*

From time to time, the Policy may be amended. When that happens, a new *Certificate, Schedule(s) of Covered Vision Services* or Amendment pages for this *Certificate* or *Schedule(s) of Covered Vision Services* will be provided to you. Your *Certificate* and *Schedule(s) of Covered Vision Services* should be kept in a safe place for your future reference.

However, this *Certificate* may be amended at any time by applicable state or Federal laws, rules and regulations. Such laws and the rules and regulations promulgated under them, when they are applicable, control and supersede this *Certificate.*

We have sole authority to interpret the benefits Covered under the Policy and the other terms, conditions, limitations and exclusions set out in the Policy and in making factual determinations related to the Policy and its benefits. We may, from time to time, delegate this authority to other persons or entities providing services in regard to the Policy.

## Contact Us

Throughout this *Certificate* you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding Vision Services or any required procedure, please contact us at 1-800-638-3120.

# Group Vision Care Certificate of Coverage Table of Contents

# Section 1: Definitions

This section defines the terms used throughout this *Certificate* and *Schedule(s) of Covered Vision Services* and is not intended to describe Covered or uncovered services.

**Amendment** - any attached description of additional or alternative provisions to the Policy. Amendments are effective only when signed by an officer of the Company. Amendments are subject to all conditions, limitations and exclusions of the Policy except for those which are specifically amended.

**Copayment** - the charge that you are responsible to pay to a Network Provider for certain Services payable under the Policy. You are responsible for the payment of any Copayment directly to the provider of the Service at the time of service, or when billed by the provider.

**Coverage or Covered** - the entitlement by a Covered Person to reimbursement for expenses incurred for Vision Services Covered under the Policy, subject to the terms, conditions, limitations and exclusions of the Policy. Vision Services must be provided: (1.) when the Policy is in effect; and (2.) prior to the date that any of the individual termination conditions as stated in *Section 3: Termination of Coverage* occur; and (3.) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

**Covered Contact Lens Selection** - 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 Copayment.

**Covered Person** - either the Subscriber or an Enrolled Dependent, while Coverage of such person under the Policy is in effect. References to you and your throughout this *Certificate* are references to a Covered Person.

**Dependent** - (1.) the Subscriber's legal spouse. or (2.) a Dependent child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, foster child, a legally adopted child or grandchild, a child or grandchild placed for adoption, or a child or grandchild for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse). To be eligible for Coverage under the Policy, a Dependent must reside within the United States. The definition of Dependent is subject to the following conditions and limitations:

A. The term Dependent will not include any Dependent child 26 years of age or older, except as stated in *Section 3: Termination of Coverage, sub-section Coverage for a Disabled Dependent Child.*

The Subscriber agrees to reimburse us for any Vision Services provided to the child at a time when the child did not satisfy these conditions.

The term Dependent also includes a child for whom vision care Coverage is required through a Qualified Medical Child Support Order or other court or administrative order. We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

The term Dependent does not include anyone who is also enrolled as a Subscriber, nor can anyone be a Dependent of more than one Subscriber.

**Eligible Person** - an employee or member of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy.

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

**Enrolling Group** - the employer or other defined or otherwise legally constituted group (Association, Union, etc.) to whom the Policy is issued.

**Experimental, Investigational or Unproven Services** - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination regarding Coverage in a particular case, is determined to be:

A. 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; or

B. Subject to review and approval by any institutional review board for the proposed use; or

C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

D. Not demonstrated through prevailing peer-reviewed 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.

**Initial Eligibility Period** - the initial period of time, determined by us and the Enrolling Group, during which Eligible Persons may enroll themselves and Dependents under the Policy.

**Network** - the collective group of Vision Providers, including specialists, who are subject to a participation agreement in effect with us, directly or through another entity, to provide Vision Services to you. The participation status of providers will change from time to time. The participation status of the provider may change based on the location where Vision Services were provided.

**Network Benefits** - benefits available for Covered Vision Services when provided by a Vision Provider who is a Network Vision Provider.

**Non-Network** - a Vision Provider who is not a participant in the Network.

**Non-Network Benefits** - Coverage available for Vision Services obtained from Non-Network Vision Providers.

**Physician** - any Doctor of Medicine, M.D., or Doctor of Osteopathy, D.O., who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

**Plan Year** - a period of time beginning with the month and day of the Policy Effective Date of any year and terminating exactly one year later. If the month and day of the Policy Effective Date is February 29, such date will be considered to be February 28 in any year having no such date.

**Policy** - the group Policy, the application of the Enrolling Group, Amendments and Riders which constitute the agreement regarding the benefits, exclusions and other conditions between us and the Enrolling Group.

**Premium** - the periodic fee required to maintain Coverage of Covered Persons in accordance with the terms of the Policy.

**Rider** - any attached description of Vision Services Covered under the Policy. Vision Services provided by a Rider may be subject to payment of additional Premiums and additional Copayments. Riders are effective only when signed by an officer of the Company and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended.

**Subscriber** - an Eligible Person who is properly enrolled for Coverage under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group. A Subscriber must reside within the United States or U.S. territories.

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

**Vision Service** - any Covered benefit listed in *Section 7: Covered Vision Services.*

# Section 2: Eligibility and Effective Date of Coverage

## Enrollment

Eligible Persons may enroll themselves and their Dependents for Coverage under the Policy during the Initial Eligibility Period by completing information provided by the Enrolling Group. In addition, new Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for Coverage under the Policy.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be Covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

## Effective Date of Coverage

In no event is there Coverage for Vision Services rendered or delivered before the Policy Effective Date of Coverage.

If an Eligible Person enrolls during the Initial Eligibility Period, Coverage is effective on the first day after any applicable waiting period required by the Enrolling Group is completed.

## Coverage for a Newly Eligible Person

Coverage for you and any of your Dependents will take effect on the date agreed to by the Enrolling Group and us. Coverage is effective only if we receive any required Premium and properly completed enrollment information within 31 calendar days of the date you first become eligible.

## Coverage for a Newly Eligible Dependent

Coverage for a new Dependent acquired by reason of birth, legal adoption, legal guardianship, placement for adoption, court or administrative order, or marriage will take effect on the date of the event. Coverage is effective only if we receive any required Premium and are notified of the event within 31 calendar days.

The newborn dependent of the Subscriber or the Subscriber's spouse is covered automatically from the moment of birth for at least 31 days.

If payment of a specific Premium is required to provide coverage, we will require notification and payment of the required Premium be furnished to us within 31 days after the birth, adoption, or date of court or testamentary appointment in order to have coverage continued beyond the 31 day period.

## Change in Family Status

You may make Coverage changes during the year for any Dependent whose status as a Dependent is affected by a marriage, divorce, legal separation, annulment, birth, legal guardianship, placement for adoption or adoption, as required by federal law. In such cases you must submit the required contribution of coverage and properly completed enrollment information within 31 calendar days of the marriage, birth, placement for adoption or adoption.

## Special Enrollment Period

An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period may enroll for Coverage during a special enrollment period. A special enrollment period is available if the following conditions are met:

A. the Eligible Person and/or Dependent had existing health coverage under another plan at the time of the Initial Eligibility Period; and

B. Coverage under the prior plan was terminated as a result of loss of eligibility (including, without limitation, legal separation, divorce or death), termination of employer contributions, or in the case of COBRA continuation coverage, the coverage was exhausted; or

C. The employee's spouse loses coverage under another group health insurance contract or policy because of the involuntary termination of the spouse's employment other than for cause.

A special enrollment period is not available if coverage under the prior plan was terminated for cause or as a result of failure to pay Premiums on a timely basis. Coverage under the Policy is effective only if we receive any required Premium and properly completed enrollment information within 6 months of the date coverage under the prior plan terminated. A special enrollment period is also available for an Eligible Person and for any Dependent whose status as a Dependent is affected by marriage, birth, placement for adoption or adoption, as required by federal law. In such cases you must submit the required Premium and properly completed enrollment information within 31 calendar days of the marriage, birth, placement for adoption or adoption.

### Coverage of Children

A Dependent child of the Subscriber may enroll at any time and without evidence of insurability if:

A. The Dependent's child previously were covered under the policy or contract of the Subscriber's or spouse; and

B. The Subscriber or Subscriber's spouse has died.

This applies regardless of whether a Subscriber's or Subscriber's dependent children are eligible for any continuation or conversion privileges under the policy or contract of the Subscriber's or Subscriber's spouse.

The Subscriber must exercise the benefit within 6 months after the death of the spouse.

## Coverage for Children Under a Medical Child Support Order

When you are required by a medical child support order to provide vision insurance for a child, the Company will permit you to enroll the child without regard to any enrollment period restrictions and add the child for vision insurance upon enrollment made by the child's non-insuring parent, by the Department of Health and Mental Hygiene, or by the state agency administering a child support enforcement program if you fail to enroll the child.

The Company will not add a child for vision insurance unless you are also insured. If you are not insured, the Company will permit you to enroll for vision insurance without regard to any enrollment period restrictions. The Company will notify you within 20 business days of receipt of medical support notice from the employer. We will determine if the notice contains the employee's name and mailing address and the child's name and the child's mailing address or the address of a substituted official.

The Company will not terminate the child's vision insurance unless satisfactory written evidence is provided that the court order is no longer in effect; the child is or will be enrolled in a comparable vision plan with another insurer that will take effect not later than the termination date of this insurance; or Dependent insurance is no longer available or you are no longer insured by the Policy.

The Company will provide to the noninsuring parent ID cards, claims forms, and any other information necessary for the child to obtain benefits through the health insurance coverage; and process the claims forms and make appropriate payment to the noninsuring parent, health care provider, or Department of Health and Mental Hygiene if the noninsuring parent incurs expenses for health care provided to the child.

# Section 3: Termination of Coverage

## Conditions for Termination of a Covered Person's Coverage Under the Policy

We may, at any time, discontinue this benefit plan and/or all similar benefit plans for the reasons specified in the Policy.

Your Coverage, including Coverage for Vision Services rendered after the date of termination for vision conditions arising prior to the date of termination, will automatically terminate on the earliest of the dates specified below.

A. The date the entire Policy is terminated, as specified in the Policy. The Enrolling Group is responsible for notifying you of the termination of the Policy.

B. The date you cease to be eligible as a Subscriber, Enrolled Dependent or active member of the Policyholder.

C. The date in which the Dependent child attains the limiting age.

D. The date we receive written notice from either the Subscriber or the Enrolling Group instructing us to terminate Coverage of the Subscriber or any Covered Person or the date requested in such notice, if later.

E. The date the Subscriber is retired or pensioned under the Enrolling Group's Plan, unless a specific Coverage classification is specified for retired or pensioned persons in the Enrolling Group's application and the Subscriber continues to meet any applicable eligibility requirements.

When any of the following apply, we will provide written notice of termination to the Subscriber.

F. The date specified by us that all Coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided us with false material information, including, but not limited to, false material information relating to residence, information relating to another person's eligibility for Coverage or status as a Dependent. We have the right to rescind Coverage back to the Policy Effective Date subject to the Contestability of Coverage provision.

G. The date specified by us that all Coverage will terminate because the Subscriber permitted the use of his or her proof of Coverage by any unauthorized person or used another person's proof of Coverage.

H. The date specified by us that Coverage will terminate due to material violation of the terms of the Policy.

I. The date specified by us that your Coverage will terminate because you failed to pay a required Premium subject to the Grace Period provision.

J. The date specified by us that your Coverage will terminate because you have committed acts of physical or verbal abuse which pose a threat to our staff, a provider, or other Covered Persons.

## Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the Coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical incapacity or disability.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless Coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 calendar days of the date Coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of Coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 calendar days of our request as described above, Coverage for that child will end.

## Payment and Reimbursement Upon Termination

Termination of Coverage will not affect any request for reimbursement for Vision Services rendered prior to the Policy Effective Date of termination. Your request for reimbursement must be furnished as required in *Section 4: Reimbursement.*

If you have ordered glasses or contact lenses before the date coverage terminates, we will continue to provide covered benefits, in accordance with the policy in effect at the time the individual's coverage terminates, for the glasses or contact lenses if you receive the glasses or contact lenses within 30 days after the date of the order.

# Section 4: Reimbursement

## Reimbursement for Services

The Covered Person will be responsible for any claims paid by us when Coverage was provided in error, except where that error was made by us. We will reimburse you for Vision Services subject to the terms, conditions, exclusions and limitations of the Policy and as described below.

## Payment of Claims

Benefits are payable not more than 30 days after receipt of acceptable written proof of loss. When obtaining Vision Services from a Network Vision Provider, you will be required to pay a Copayment and any charges not Covered by the Policy to your Vision Provider. When obtaining Services from a Network Vision Provider, you will not be required to submit a claim form. Benefits for services rendered by a Network Vision Provider will be paid directly to the preferred provider rendering the services.

Benefits are payable not more than 30 days after receipt of acceptable written proof of loss. When obtaining Vision Services from a Non-Network Vision Provider, you will be responsible to pay all billed charges to your Vision Provider. You may then obtain payment from us for the Covered portion of Vision Services.

## Filing Claims for Reimbursement

You are responsible for submitting a request in writing for reimbursement to our office. Requests for reimbursement should be submitted within 90 calendar days after the date of service.

**Claim Forms.** It is not necessary to include a claim form with the proof of loss. However, the proof of loss that you submit to us must include all of the following information:

- Your name and address; and
- Patient's name and age; and
- Your identification number; and
- The name and address of the provider(s) of the services(s); and
- Itemized bill which includes a description of each charge; and
- A statement indicating that you are or you are not enrolled for coverage under any other health or vision insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

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. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above to Claims Department, PO, Box 30978, Salt Lake City, UT 84130 or by fax to 248-733-6060.

**Proof of Loss.** Written proof of loss is not required before 20 days after the occurrence or commencement of the date of loss. Failure to furnish the request for payment within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the request within the required time, if the request is furnished as soon as reasonably possible and, except in the absence of a legal capacity of the claimant, not later than one year from the time the proof is otherwise required.

## 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 Services from a Non-Network Vision Provider. However, the amount of Coverage may be reduced.

## Foreign Services

Foreign Services will be treated as Non-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 Services were rendered.

# Section 5: Questions, Complaints and Appeals

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

## What to Do if You Have a Question

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

## What to Do if You Have a Complaint

Contact *Customer Service* at 1-800-638-3120. *Customer Service* 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 Customer Service representative can provide you with the appropriate address.

If the Customer Service representative cannot resolve the issue to your satisfaction 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.

## Adverse Decisions, Adverse Decision Grievances and Adverse Decision Complaints

### Defined Terms

For the purpose of this Section, the following terms have the following meanings:

- "Adverse decision" is our determination that a proposed or delivered Covered Health Service which would otherwise be covered under the Policy is not or was not, appropriate or efficient, and may result in non-coverage of the health service.
- "Adverse decision complaint" is a protest filed with the Insurance Commissioner involving an adverse decision or grievance decision concerning a Covered Person.
- "Adverse decision grievance" means a protest by you, your representative, or your health care provider on your behalf with us through our internal grievance process regarding an adverse decision.
- "Compelling reason" means a showing that the potential delay in receipt of a health care service until after the member or health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the member remaining seriously mentally ill with symptoms that cause the member to be in danger to self or others.
- "Complaint" is a protest filed with the Insurance Commissioner that is either; a) an adverse decision complaint, or b) a complaint as allowed under the provision entitled *Complaints* below.
- "Filing date" is the earlier of five days after the date the adverse decision grievance was mailed or the date of receipt.
- "Grievance decision" is a final determination by us that arises from an adverse decision grievance filed with us under our internal adverse decision grievance process regarding an adverse decision.
- "Health Advocacy Unit" means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.
- "Health care provider" means a Hospital, or an individual who is licensed or otherwise authorized in the State of Maryland to provide health care services in the ordinary course of working or practice of a profession and is a treating provider of a Covered Person.
- "Your representative" means an individual who has been authorized by you to file a grievance or a complaint on your behalf.

## Notice Requirements

All notification requirements provided to you, your representative, and/or your health care provider as described in this Section will be provided in a culturally and linguistically appropriate manner and will be provided within 30 calendar days after the appeal decision has been made.

## Complaints

You, your representative, or your health care provider filing a complaint on a your behalf, may file a complaint with the Commissioner without first filing an adverse decision grievance with us and receiving a grievance decision if:

- We waive the requirement that our internal grievance process be exhausted before filing a complaint with the Commissioner;
- We have failed to comply with any of the requirements of the internal grievance process as described in this section;
- You, your representative, or your health care provider provides sufficient information and supporting documentation in the complaint that demonstrates a compelling reason for the complaint; or
- Your complaint is based on one of the exceptions as described below under *Internal Adverse Decision Grievance Process.*

## Internal Adverse Decision Grievance Process

Under the law, you must exhaust our internal adverse decision grievance process before you, your representative or your health care provider file an adverse decision complaint with the Insurance Commissioner, unless the adverse decision involves a compelling reason for which services have not already been rendered, or is described above under *Complaints,* or unless it is under one of the other circumstances outlined below. For retrospective denials (denials on health services which have already been rendered), a compelling reason may not be shown. If the adverse decision by us involves a condition establishing a compelling reason for which services have not been rendered, you, your representative or your health care provider may address your complaint directly to the Insurance Commissioner without first directing it to us.

## Adverse Decisions

We will not make an adverse decision retrospectively regarding preauthorized or approved Covered Health Services delivered to a Covered Person, unless such preauthorization or approval was based on fraudulent, intentionally misrepresented, or omitted information. Such omitted information must have been critical requested information regarding the Covered Health Services whereby the preauthorization or approval for such Covered Health Services would not have been approved if the requested information had been received.

For non-Emergency cases, if we render an adverse decision, a notice of this adverse decision will be verbally communicated to you, your representative, or your health care provider.

We will document the adverse decision in writing after we have provided the verbal communication of the adverse decision as described above.

Written notification of the adverse decision will be sent to you, your representative, and your health care provider within five working days after the adverse decision has been made.

For Emergency case adverse decisions timeframes, see below under the provision entitled *Expedited Review in Emergency Cases.*

The adverse decision will be accompanied by a Notice of Adverse Decision attachment. This Notice will include the following information:

- Details concerning the specific factual basis for the denial in clear, understandable language;
- The specific criteria or guidelines on which the decision is based;
- The name, business address and direct telephone number of the Medical Director who made the decision;
- Written details of our internal adverse decision grievance process and procedures;
- The right for you, your representative, or your health care provider on your behalf, to file an adverse decision complaint with the Insurance Commissioner within four months of receipt of our adverse grievance decision;
- The right for you, your representative, or your health care provider on your behalf, to file an adverse decision complaint with the Insurance Commissioner without first filing an adverse decision grievance with us if you,

your representative, or your health care provider acting on your behalf can demonstrate a compelling reason to do so.

- The Insurance Commissioner's address, telephone number and fax number; and
- The information shown below regarding assistance from the Health Advocacy Unit.

## Adverse Decision Grievances

If you, your representative or your health care provider have received an adverse decision, you, your representative, or your health care provider on your behalf, have the right to file an adverse decision grievance with us. The following conditions apply to adverse decision grievance filings:

- The adverse decision grievance may be filed by you, your representative, or your health care provider on your behalf. If the adverse decision is a retrospective denial, you, your representative or your health care provider have up to 180 days from the date of receipt to file an adverse decision grievance.
- For prospective denials (denials on health services that have not yet been rendered), we will render a grievance decision in writing within 30 working days after the filing date, unless it involves an emergency case as explained below. Unless written permission has been given per the fourth bulleted item below, you, your representative, or your health care provider on your behalf, have the right to file an adverse decision complaint with the Insurance Commissioner, if you, your representative or your health care provider have not received our grievance decision on or before the 30th working day after the filing date.
- For retrospective denials (denials on health services that have already been rendered), we will render a grievance decision within 45 working days after the filing date.
- Unless written permission has been given, you, your representative, or your health care provider on your behalf, have the right to file an adverse decision complaint with the Insurance Commissioner (see below), if you, your representative or your health care provider have not received our grievance decision on or before the 45th working day after the filing date.
- With written permission from you, your representative, or your health care provider on your behalf, the time frame within which we must respond can be extended up to an additional 30 working days.
- If we need additional information in order to review the case, we will notify you, your representative and/or your health care provider within five working days after the filing date. We will assist you, your representative, or the health care provider in gathering the necessary medical records without further delay. If no additional information is available or is not submitted to us, we will render a decision based on the available information.
- Except as described under the first two bullets in the *Complaints* provision above, for retrospective denials, you, your representative, or your health care provider on your behalf, must file an adverse decision grievance with us before filing an adverse decision complaint with the Insurance Commissioner, as described in the Assistance From Health Education and Advocacy Unit provision.
- Notice of our grievance decision may be verbally communicated to you, your representative, or your health care provider. Written notification of our grievance decision will be sent to you, your representative and any health care provider who filed an adverse decision grievance on your behalf within five working days after the grievance decision has been made. If we uphold the adverse determination, the denial notification will include a Notice of Grievance Decision. This Notice will include the information in the bulleted items under Adverse Decision above. This notice will also include a statement that the Health Advocacy Unit is available to assist you or your representative in filing a complaint with the Commissioner.
- If any new or additional evidence is relied upon or generated by us during the determination of the adverse decision grievance, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.
- For prospective denials, you, your representative, or your health care provider on your behalf, may file an adverse decision complaint with the Insurance Commissioner (see below) without first filing an adverse decision grievance with us, if you, your representative, or your health care provider can demonstrate that the adverse decision concerns a compelling reason for which a delay would result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ or the Covered Person remaining seriously mentally ill with symptoms that cause the Covered Person to be in danger to self or others.

## Expedited Review in Emergency Cases

In emergency cases, you, your representative or your health care provider may request an expedited review of an adverse decision. An "emergency case" is a case involving an adverse decision of proposed health services which are necessary to treat a condition or illness that, without immediate medical attention, would seriously jeopardize the life or health of the Covered Person or his or her ability to regain maximum function, or would cause the Covered Person to be in danger to self or others.

The procedure listed below will be followed:

- If the health care provider filed the adverse decision grievance, he or she will determine whether the basis for an emergency case or expedited review exists. If the Covered Person, or the Covered Person's representative, filed the adverse decision grievance, we, in consultation with the health care provider, will determine whether the basis for an emergency case or expedited review exists. In either case, the determination will be based on the above definition of "emergency case".
- We will render a verbal grievance decision to an adverse decision grievance filed by you, your representative, or your health care provider on your behalf, within 24 hours of the date a grievance is filed with us of the adverse decision grievance. Within one day after the verbal grievance decision has been communicated, we will send notice in writing of any adverse decision grievance to you, your representative, and if applicable, your health care provider. If we need additional information in order to review the case, we will verbally inform you, your representative and/or your health care provider, and will assist with procuring the additional information. If we do not render a grievance decision within 24 hours, you, your representative, or your health care provider may file an adverse decision complaint directly with the Insurance Commissioner. If we uphold our decision to deny coverage for the Covered Health Services, we will send you, your representative and/or your health care provider the grievance decision in writing within one day of the verbal notification. The Notice of Grievance Decision will include the information specified for the Notice of Adverse Decision above and will include that the Health Advocacy Unit is available to assist you or your representative in filing a complaint with the Commissioner.

## Assistance From the Health Education and Advocacy Unit

THERE IS HELP AVAILABLE TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES. The Health Advocacy Unit is available to assist you or your representative with filing an adverse decision grievance under our internal adverse decision grievance process and assist you or your representative in mediating a resolution of our adverse decision. NOTE: The Health Advocacy Unit is not available to represent or accompany you or your representative during the proceedings. The Health Advocacy Unit may be reached at:

Health Education and Advocacy Unit

Consumer Protection Division

Office of the Attorney General

200 St. Paul Place, 16th Floor

Baltimore, Maryland 21202

410-528-1840 or 1-877-261-8807 (toll free)

Fax number: 410-576-6571

TTY: 1-800-735-2258

E-mail: consumer@oag.state.md.us

## Medical Directors

Our Medical Directors who are responsible for adverse decisions and grievance decisions may be reached at:

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

301-762-8205/ 1-800-544-2853

## Adverse Decision Complaints to the Insurance Commissioner

Within four months after receiving our Notice of Grievance Decision, or under the circumstance s described above in the Complaints provision, you, your representative or your health care provider on your behalf, may submit an adverse decision complaint to the Insurance Commissioner at:

Maryland Insurance Administration

Appeals and Grievance Unit

200 St. Paul Place, Suite 2700

Baltimore, Maryland 21202

1-800-492-6116 or 410-468-2000

TTY: 1-800-735-2258

Fax Number 410-468-2270

When filing a complaint with the Insurance Commissioner, you or your representative will be required to authorize the release of any medical records of the Covered Person that may be required to be reviewed for the purpose of reaching a decision on the complaint.

The Health Advocacy Unit is available to assist you or your representative in filing a complaint with the Insurance Commissioner.

Health Education and Advocacy Unit

200 St. Paul Place, 16th Floor

Baltimore, Maryland 21202

Telephone number: (410) 528-1840

Fax number: (410) 576-6571

TTY: 1-800-735-2258

E-mail: consumer@oag.state.md.us

The Insurance Commissioner will make a final decision on a complaint as follows:

- For an emergency case, written notice of the Insurance Commissioner's final decision will be sent to the Covered Person, the Covered Person's representative and/or the health care provider within one day after the Insurance Commissioner has given verbal notification of the final decision.
- For an adverse decision complaint involving a pending health service, written notice of the Insurance Commissioner's final decision will be sent to he Covered Person, the Covered Person's representative and/or the health care provider within 45 days after the adverse decision complaint is filed.
- For an adverse decision complaint involving a retrospective denial of health services already provided, written notice of the Insurance Commissioner's final decision will be sent to the Covered Person, the Covered Person's representative and/or the health care provider within 45 days after the adverse decision complaint is filed.

Except for emergency cases, the time periods above for notification may be extended if additional information is necessary in order for the Insurance Commissioner to render a final decision, or if it is necessary to give priority to adverse decision complaints regarding pending health services.

## Assistance from State Agencies

Governmental agencies are available to assist you with complaints that are not a result of an adverse decision as described above.

For quality of care issues and health care insurance complaints, contact the Consumer Complaint & Investigation at:

Consumer Complaint & Investigation

Life and Health

Maryland Insurance Administration

200 St. Paul Place, Suite 2700

Baltimore, Maryland 21202

Telephone number: 1-800-492-6116

Fax number: (410) 468-2270 or (410) 468-2260

TTY: 1-800-735-2258

For assistance in resolving a billing or payment dispute with the Company or a provider, contact the Health Advocacy Unit at:

Office of the Attorney General

Health Education and Advocacy Unit

200 St. Paul Place, 16th Floor

Baltimore, Maryland 21202

Telephone number: (410) 528-1840

Fax number: (410) 576-6571

TTY: 1-800-735-2258

E-mail: consumer@oag.state.md.us

## Coverage and Appeal Decisions

For the purpose of this section, the following terms have the following meanings:

- "Appeal" means a protest filed by a Covered Person, a Covered Person's representative or a health care provider with us under our internal appeal process regarding a coverage decision concerning a Covered Person.
- "Appeal decision" means a final determination made by us that arises from an appeal filed with us under our appeal process regarding a coverage decision concerning a Covered person.
- "Coverage decision" means:
  - an initial determination by us or our representative that results in non-coverage of a health care service;
  - a determination by us that an individual is not eligible for coverage under the Policy;
  - any determination by us that results in the rescission of an individual's coverage under the Policy.

    A coverage decision includes a nonpayment of all or any part of a claim.

    A coverage decision does not include:

    - an adverse decision as described above; or
    - a pharmacy inquiry.
- "Health Advocacy Unit" means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.
- "Pharmacy inquiry" means an inquiry submitted by a pharmacist or pharmacy on behalf of a Covered Person to us or a pharmacy benefits manager at the point of sale about the scope of pharmacy coverage, pharmacy benefit design, or formulary, if available, under the Policy.
- "Your representative" means an individual who has been authorized by you to file an appeal or a complaint on your behalf.

If a coverage decision results in non-coverage of a health care service including non-payment of all or any part of your claim, you, your representative, or your health care provider acting on your behalf, have a right to file an appeal within one hundred eighty (180) calendar days of receipt of the coverage decision. The appeal may be submitted verbally or in writing and should include any information you, your representative or a health care provider acting on your behalf believe will help us review your appeal. You, your representative or a health care

provider acting on your behalf may call *Customer Care* at the phone number listed on your identification card to verbally submit your appeal. Send the written appeal to: Customer Support Group, P.O. Box 933, Frederick, MD 21705. Within thirty (30) calendar days after the appeal decision has been made, we will send you, your representative and your health care provider acting on your behalf, a written notice of the appeal decision.

Notice of an appeal decision will include the following:

- Details concerning the specific factual basis for the decision in clear, understandable language;
- The right for you, your representative, or a health care provider acting on your behalf, to file a complaint with the Insurance Commissioner within four months of receipt of our appeal decision;
- The Insurance Commissioner's address, telephone number and fax number;
- A statement that the Health Advocacy Unit is available to assist you in filing a complaint with the Commissioner; and
- The information shown below regarding assistance from the Health Advocacy Unit.

If you are dissatisfied with the outcome of the appeal, you, your representative or a health care provider acting on your behalf may file a complaint with the Life and Health Complaint Unit, Maryland Insurance Administration, *within four months after receipt of the appeal decision.* You, your representative or a health care provider acting on your behalf may contact the Life and Health Complaint Unit, Maryland Insurance Administration, at 200 St. Paul Place, Suite 2700, Baltimore, MD 21202, phone (410) 468-2000, toll free (800) 492-6116 or facsimile (410) 468-2260.

The Insurance Commissioner may request that you, your representative or a health care provider acting on your behalf whom filed the complaint, to sign a consent form authorizing the release of your medical records to the Insurance Commissioner or the Insurance Commissioner's designee that are needed in order to make a final decision on the complaint.

You, your representative, or a health care provider acting on your behalf may contact the Health Advocacy Unit at:

Health Education Advocacy Unit

Consumer Protection Division

Office of the Attorney General

200 St. Paul Place, 16th Floor

Baltimore, MD 21202

Telephone: 410/528-1840 or toll free at 1-877/261-8807; Fax#: 410/576-6571; TTY: 1-800-735-2258

Website address: www.oag.state.md.us

The Health Advocacy Unit can help you, your representative or a health care provider acting on your behalf prepare an appeal to file under our internal appeal procedure. That unit can also attempt to mediate a resolution to your dispute. The Health Advocacy Unit is not available to represent or accompany you or your representative during any proceeding of the internal appeal process.

Additionally, you, your representative or a health care provider acting on your behalf may file a complaint with the Life and Health Complaint Unit, Maryland Insurance Administration, without having to first file an appeal with us if (1) we have denied authorization for a health service not yet provided to you, and (2) you or the health care provider gives sufficient information and supporting documentation in the complaint that demonstrates a compelling reason exists.

# Section 6: General Legal Provisions

## Entire Policy

The Policy issued to the Enrolling Group, including the Certificate(s), Schedule(s) of Covered Vision Services, the Enrolling Group's application, Amendments and Riders, constitute the entire Policy.

## Contestability of Coverage

A statement made by any Covered Person under the Policy relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of 2 years during the Covered Person's lifetime.

No statement will be used to void or reduce coverage under this Policy unless:

- The statement is contained in a written instrument signed by the Enrolling Group or the Subscriber, and
- A copy of the statement is given to the Enrolling Group, Subscriber or beneficiary of the Subscriber.

## Amendments and Alterations

Amendments to the Policy are effective upon 31 calendar days prior written notice to the Enrolling Group. Riders are effective on the date specified by us. No change will be made to the Policy unless it is made by an Amendment or a Rider that is signed by an officer of the Company. No agent has authority to change the Policy or to waive any of its provisions.

## Relationship Between Parties

The relationships between us and Network Vision Providers and relationships between us and Enrolling Groups are solely contractual relationships between independent contractors. Network Vision Providers and Enrolling Groups are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of Network Vision Providers or Enrolling Groups.

The relationship between a Network Vision Provider and any Covered Person is that of Vision Provider and patient. The Network Vision Provider is solely responsible for the services provided to any Covered Person. The Enrolling Group is solely responsible for enrollment and Coverage classification changes (including termination of a Covered Person's Coverage through the Company) and for the timely payment of the Policy Charge.

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

## Information and Records

At times we may need additional information from you. You agree to furnish us with all information and proof that we may reasonably require regarding any matters pertaining to the Policy. If you do not provide this information when we request it, we may delay or deny payment of your Coverage.

By accepting Coverage 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 any and all records concerning vision care services which are necessary to implement and administer the terms of the Policy, for appropriate review or quality assessment, or as we are required to do 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.

For complete listings of your vision records or billing statements, we recommend that you contact your Vision Provider. Vision 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, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

## ERISA

When the Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

## Examination of Covered Persons

In the event of a question or dispute concerning Coverage for Vision Services, we may reasonably require that a Network Vision Provider acceptable to us examine you at our expense.

## Clerical Error

If a clerical error or other mistake occurs, that error will not deprive you of Coverage under the Policy. A clerical error also does not create a right to benefits or Coverage.

## Notice

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

## Workers' Compensation Not Affected

The Coverage provided under the Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

## Conformity with Statutes

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

## Waiver/Estoppel

Nothing in the Policy, *Certificate* or *Schedule(s) of Covered Vision Services* is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy, *Certificate* or *Schedule(s) of Covered Vision Services,* or to exercise any option which is herein provided, shall in no way be construed to be a waiver of such provision of the Policy, *Certificate* or *Schedule(s) of Covered Vision Services.*

## Headings

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

## Unenforceable Provisions

If any provision of the Policy, *Certificate* or *Schedule(s) of Covered Vision Services* is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Policy, *Certificate* or *Schedule(s) of Covered Vision Services* to the greatest extent legally permissible.

## Misstatement of Age

If the Company's records show an incorrect age for a Covered Person, the Company will pay benefits according to what would have been provided for the correct age.

If benefits were underpaid, the Company will pay the additional amount that is due.

If benefits were overpaid, the Company reserves the right to recover the amount of the overpaid benefit from the person who received the payment; or reduce future benefit payments by the amount of the overpayment.

The Company also reserves the right to make an equitable Premium adjustment based on the error.

## Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the Coverage provided by this *Certificate,* we shall also have an independent right to be reimbursed by you for the reasonable value of any services and benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
  - Providing any relevant information requested by us.
  - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of vision benefits or the instigation of legal action against you.
- That we have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of vision benefits or the instigation of legal action against you.

- That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits we provided, plus reasonable costs of collection.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Proceeds received by us will be reduced by a pro rate share of the court costs and legal fees incurred by the Covered Person applicable to the portion of the settlement returned to us. The Covered Person agrees to execute and deliver such documents (including a written confirmation of assignment, and consents to release medical records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request.

## Refund of Overpayments

If we pay benefits for expenses incurred on account of you, that 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 by you 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, then you agree to help us get the refund when requested.

If you do not promptly refund the full amount, we may reduce the amount of any future benefits for you that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

## Limitation of Action

You cannot bring any legal action against us until 60 days after you have properly submitted a request for proof of loss as described in Section 4: Reimbursement. If you want to bring a legal action against us you must do so within three years of the date written proof of loss is required to be furnished.

# Section 7: Covered Vision Services

## Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Covered Person resides including:

A. A case history, including chief complaint and/or reason for examination, patient medical/eye history, current medications, etc.;

B. Recording of monocular and binocular visual acuity, far and near, with and without present correction (20/20, 20/40, etc.);

C. Cover test at 20 feet and 16 inches (checks eye alignment);

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

E. Pupil responses (neurological integrity);

F. External exam;

G. Refraction (when applicable) - to determine power of corrective lenses for distance and near vision;

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

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

J. Ophthalmoscopic examination of the internal eye;

K. Confrontation visual fields;

L. Biomicroscopy;

M. Color vision testing;

N. Diagnosis/prognosis;

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

P. Specific recommendations.

Or in lieu of a routine exam, Refraction to determine power of corrective lenses for distance and near vision.

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

## Eyeglass Lenses

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

## Eyeglass Frames

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

## 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, tinted lenses, polycarbonate lenses, high-index lenses, progressive lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photochromic coating.

## Contact Lenses

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

## 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; or

F. Corneal deformity.

## 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. It may include up to 2 follow-up visits as needed. Contact Lens benefits include the fitting/evaluation fees and contacts.

## Right to Request Referral to Specialist

If you are diagnosed with a condition or disease that requires specialized health care services or medical care you may request a referral to a specialist or non-physician specialist who is not part of our provider panel if:

A. The procedure shall provide for a referral to a specialist or non-physician specialist who is not part of our provider panel and;

B. We do not have in our provider panel a specialist or non-physician specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or.

C. We cannot provide reasonable access to a specialist or non-physician specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.

# Section 8: General Exclusions

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 Services.*

B. Services that the Covered Person, without cost, obtains from any governmental organization or program; this does not include Medicaid.

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

D. Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.

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

F. Replacement or repair of lenses and/or frames that have been lost or broken.

G. Optional Lens Extras not listed in the *Schedule(s) of Covered Vision Services.*

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 Coverage 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.

N. Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by 1-302 of the *Maryland Health Occupations Article.*

# Schedule of Covered Vision Services

The following Vision Services will be covered, subject to a Copayment, when obtained from Network Providers.

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

When obtaining these Vision Services from a non-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 non-Network Providers will be limited to the amounts noted in the column "Non-Network Benefit" in the chart below.

| **SERVICE** | **FREQUENCY OF SERVICE** | **NETWORK BENEFIT** | **NON-NETWORK BENEFIT** |
|---|---|---|---|
| Routine Vision Examination | Once every 12 months | After a Copayment of $15.00 . | To a maximum of a $40.00 allowance. |
| Refraction Only in Lieu of Routine Vision Examination | Once every 12 months | $0 allowance | To a maximum of a $40.00 allowance. |
| Contact Lens Fitting and Evaluation | Once every 12 months | After a Copayment of $30.00 . One Copayment for Contact Lens Fitting and Evaluation and Contact Lenses combined if from the Covered Contact Lens Selection.<br><br>To a maximum of a $105.00 allowance for Contact Lens Fitting and Evaluation and Contact Lenses combined if not from the Covered Contact Lens Selection. | To a maximum of a $105.00 allowance. |
| Eyeglass Frames[A] | Once every 12 months | After a Copayment of $30.00 [B] to a maximum of a $130 allowance. | To a maximum of a $45.00 allowance. |
| Eyeglass Lenses[A] | Once every 12 months | | |

| | | | |
|---|---|---|---|
| Single Vision* | | After a Copayment of $30.00 .[B] | To a maximum of a $40.00 allowance. |
| Bifocal-lined | | After a Copayment of $30.00 .[B] | To a maximum of a $60.00 allowance. |
| Trifocal-lined | | After a Copayment of $30.00 .[B] | To a maximum of a $80.00 allowance. |
| Lenticular | | After a Copayment of $30.00 .[B] | To a maximum of a $80.00 allowance. |
| Contact Lenses[A] | Once every 12 months | After a Copayment of $30.00 for up to 4 boxes from the Covered Contact Lens Selection.[C] One Copayment for Contact Lens Fitting and Evaluation and Contact Lenses combined if from the Covered Contact Lens Selection.<br><br>To a maximum of a $105.00 allowance for Contact Lens Fitting and Evaluation and Contact Lenses combined if not from the Covered Contact Lens Selection.[C] | To a maximum of a $105.00 allowance. |
| Necessary Contact Lenses[A] | Once every 12 months | After a Copayment of $30.00 . | To a maximum of a $210.00 allowance. |

Optional Lens Extras:

- Eyeglass Lenses: The following Optional Lens Extras are covered in full:
  - Scratch-resistant coating

[A]You are eligible to select only one of either eyeglasses (Eyeglass Lenses/or Eyeglass Lenses and Eyeglass Frames) or Contact Lenses. If you select more than one of these Vision 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.

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

[C]Coverage for Covered Contact Lens Selection will not apply at Walmart, Sam's Club and Costco locations. The allowance for lens not from the Covered Contact Lens Selection will be used.

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

## 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. E.T.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

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 số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises 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。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

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 shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

## 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
United Healthcare 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. E.T.

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 either a claim determination or a rescission of coverage determination, you can contact us in writing to formally 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 appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a Vision Provider with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, vision experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent 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 relevant to your claim for benefits. In addition, 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.

## Appeals Determinations

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

- For appeals of claims as identified above, the appeal will be conducted and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

Please note that our decision is based only on whether or not benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending Vision Service is necessary or appropriate. That decision is between you and your Vision Provider.

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.

# 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, 2018

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 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 relating 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 health plan, we will post the revised notice on your vision plan website, such as www.myuhcvision.com. We reserve 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's 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; and
- 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 necessary 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 and 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 evaluation 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 necessary 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 necessary (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 necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and 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. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
    - 1. HIV/AIDS;
    - 2. Mental health;
    - 3. Genetic tests;
    - 4. Alcohol and drug abuse;
    - 5. Sexually transmitted diseases and reproductive health information; and
    - 6. Child or adult abuse or neglect, including sexual assault.

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. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth 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, contact the phone number listed on the back of 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 modify 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 obtain 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 pursuant 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 obtain 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 the back of your vision plan ID card or you may contact the *UnitedHealth Group Customer Call Center* Representative at 1-800-638-3120 (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, for 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 Medical Information Privacy Notice applies to the following health plans that are affiliated with UnitedHealth Group: UnitedHealthcare Insurance Company and UnitedHealthcare Insurance Company of New York.

# FINANCIAL INFORMATION PRIVACY NOTICE

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

**PLEASE REVIEW IT CAREFULLY.**

*Effective January 1, 2018*

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**

We 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; and
- 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; and
- To nonaffiliated companies that perform services for us, including sending promotional communicati ons 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 the back of your vision plan ID card or contact the UnitedHealth Group Customer Call Center at 1-800-638-3120 (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 last page of the Medical Information Privacy Notice, 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.

## UNITEDHEALTH GROUP

## VISION PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS

Revised: January 1, 2018

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

- show the categories of health information that are subject to these more restrictive laws; and
- give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

**Summary of Federal Laws**

| **Alcohol & Drug Abuse Information** |
|---|
| We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients. |
| **Genetic Information** |
| We are not allowed to use genetic information for underwriting purposes. |

**Summary of State Laws**

| **General Health Information** | |
|---|---|
| We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients. | AR, CA, DE, NE, NY, PR, RI, UT, VT, WA, WI |
| HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions. | KY |
| You may be able to restrict certain electronic disclosures of such health information. | NC, NV |
| We are not allowed to use health information for certain purposes. | CA, IA |
| We will not use and/or disclose information regarding certain public assistance programs except for certain purposes. | KY, MO, NJ and SD |
| We must comply with additional restrictions prior to using or disclosing your health information for certain purposes. | KS |
| **Prescriptions** | |
| We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients. | ID, NH, NV |

| | |
|---|---|
| **Communicable Diseases** | |
| We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients. | AZ, IN, KS, MI, NV, OK |
| **Sexually Transmitted Diseases and Reproductive Health** | |
| We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients. | CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY |
| **Alcohol and Drug Abuse** | |
| We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients. | AL, AR, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI |
| Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information. | WA |
| **Genetic Information** | |
| We are not allowed to disclose genetic information without your written consent. | CA, CO, KS, KY, LA, NY, RI, TN, WY |
| We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients. | AK, AZ, FL, GA, IA, MD, ME, MA, MO, NJ, NV, NH, NM, OR, RI, TX |
| Restrictions apply to (1) the use, and/or (2) the retention of genetic information. | FL, GA, IA, LA, MD, NM, OH, UT, VA, VT |
| **HIV / AIDS** | |
| We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients. | AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NH, NM, NV, NY, NC, OR, PA, PR, RI, TX, VT, WA, WV, WI, WY |
| Certain restrictions apply to oral disclosures of HIV/AIDS-related information. | CT, FL |
| We will collect certain HIV/AIDS-related information only with your written consent. | OR |
| **Mental Health** | |
| We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients. | CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI |
| Disclosures may be restricted by the individual who is the subject of the information. | WA |
| Certain restrictions apply to oral disclosures of mental health information. | CT |
| Certain restrictions apply to the use of mental health information. | ME |

| **Child or Adult Abuse** | |
|---|---|
| We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients. | AL, CO, IL, LA, NE, NJ, NM, NY, RI, TN, TX, UT, WI |

# 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) 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 obtain, 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) 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 as a result of 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 obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA,* there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration.*

**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 pursuant 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.