Summary Plan Description

Palm Beach County Board of County Commissioners

Vision Plan

Vision Plan Code: F3391

EFFECTIVE: January 1, 2023

GROUP NUMBER: 929250

United Healthcare

Table of Contents

Summary Plan Description

United Healthcare Services, Inc.

What Is the Summary Plan Description?

This *Summary Plan Description (SPD)* is a summary of the Covered Vision Care Services, available to you under the Palm Beach County Board of County Commissioners ("Plan Sponsor") Self-Funded vision benefit plan. This SPD is a legal document that describes Benefits for the portion for which United Healthcare Services, Inc. ("Claims Administrator") administers claim payment, either directly or indirectly with one of the Claim Administrator's affiliates.

For the purposes of this provision "Self-Funded" means that the Plan Sponsor, on behalf of the Plan, has the sole responsibility to pay, and provide funds, to pay for all Plan benefits. The Claims Administrator has no liability or responsibility to provide these funds. The Claims Administrator is a private healthcare claims administrator. The Claims Administrator is not the Plan Administrator for the Plan. Although the Claims Administrator will assist you in many ways, it does not guarantee any Benefits. The Plan Sponsor is solely responsible for the benefit plan design and funding payment of Benefits.

In addition to this *SPD,* the Plan includes:

- The *Schedule of Benefits*.
- Amendments.
- Addendums.
- Summary Material Modification (SMM).

Can This SPD Change?

The Plan Sponsor may, from time to time, change this *SPD* by attaching legal documents called SMMs and/or Amendments that may change certain provisions of this *SPD*. When this happens the Plan Sponsor will send you a new *SPD*, SMM or Amendment.

Other Information You Should Have

The Plan Sponsor intends to continue this Plan, but reserves the right, in its sole discretion, to change, interpret, withdraw or add Benefits, or to end the Plan, as permitted by law, without your approval, subject to any collective bargaining agreements, if applicable.

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

The Policy will take effect on the date shown in the Plan. Coverage under the Policy starts at 12:01 a.m. and ends at 12:00 midnight in the time zone of the Plan Sponsor's location.

The Plan is not subject to ERISA. To the extent other federal law (e.g. PHSA, IRC) does not apply, Florida law governs the Plan and Utah is the Essential Health Benefits Benchmark.

Introduction to Your SPD

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

What Are Defined Terms?

Certain capitalized words have special meanings. The Plan Sponsor has defined these words in *Section 9: Defined Terms, in the Medical SPD.*

When the Plan Sponsor uses the words "you" and "your," the Plan Sponsor is referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms, in the Medical SPD.*

How Do You Use This Document?

Read your entire *SPD* and any attached Summary Material Modifications (SMMs) and/or Amendments. You may not have all of the information you need by reading just one section. Keep your *SPD* and *Schedule of Benefit* and any attachments in a safe place for your future reference. You can also get this SPD at www.myuhcvision.com.

Review the Benefit limitations of this *SPD* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Vision Care Services* and *Section 2: Exclusions and Limitations*. Read *Section 8: General Legal Provisions* to understand how this *SPD* and your Benefits work. Call the Claims Administrator if you have questions about the limits of the coverage available to you.

If there is a conflict between this *SPD* and any summaries provided to you by the Plan Sponsor, this *SPD* controls.

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

How Do You Contact the Claims Administrator?

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

Your Responsibilities

Enrollment and Required Contributions

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

- Your enrollment must be in accordance with the requirements of the Plan issued to your Plan Sponsor, including the eligibility requirements.
- You must qualify as a Participant or a Dependent as those terms are defined in *Section 9: Defined Terms, in the Medical SPD.*

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

Be Aware the Plan Does Not Pay for All Vision Care Services

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

Decide What Services You Should Receive

Care decisions are between you and your Vision Provider. The Claims Administrator and the Plan Sponsor do not make decisions about the kind of care you should or should not receive.

Choose Your Vision Provider

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

Pay Your Share

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

Pay the Cost of Excluded Services

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

Show Your ID Card

You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information

When you receive Covered Vision Care Services from an out-of-Network Vision Provider, you are responsible for requesting payment from the Plan. You must file the claim in a format that contains all of

the information the Claims Administrator requires to process the claim, as described in *Section 5: How to File a Claim*.

Claims Administrator and Plan Sponsor Responsibilities

Determine Benefits

The Claims Administrator makes administrative decisions regarding whether the Plan will pay for any portion of the cost of a health care service you intend to receive or have received. The Claims Administrator's decisions are for payment purposes only. The Claims Administrator does not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

The Claims Administrator has the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *SPD*, the *Schedule of Benefits* and any SMMs and/or Amendments.
- Make factual determinations relating to Benefits.

The Plan Sponsor assigns the discretionary authority to the Claims Administrator who may assign this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide administrative services for the Plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

Process Payment for the Plan's Portion of the Cost of Covered Vision Care Services

The Claims Administrator processes the Plan's payment of Benefits for Covered Vision Care Services as described in *Section 1: Covered Vision Care Services* and in the *Schedule of Vision Care Services*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means the Claims Administrator processes only the payment of the Plan's portion of the cost of Covered Vision Care Services. It also means that not all of the vision care services you receive may be paid for (in full or in part) by the Plan.

Process Plan Payment to Network Providers

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

Process Plan Payment for Covered Vision Care Services Provided by Out-of-Network Providers

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

Schedule of Covered Vision Care Services

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

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

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

SERVICE[M, K]	FREQUENCY OF SERVICE	NETWORK BENEFIT The Amount You Pay	OUT-OF-NETWORK BENEFIT
Routine Vision Examination for Dependent children up to age 13	Twice every 24 months[A1]	Co-payment of $10.	To a maximum of a $45 allowance[O].
Routine Vision Examination for Covered Persons age 13 or older	Once every 24 months	Co-payment of $10.	To a maximum of a $45 allowance[O].
Routine Vision Examination for the following conditions: pregnancy or breastfeeding	Twice every 24 months[A1]	Co-payment of $10.	To a maximum of a $45 allowance[O].
Refraction Only in lieu of Routine Vision Examination for Dependent children up to age 13	Twice every 24 months[A1]	To a maximum of a $0 allowance.	To a maximum of a $45 allowance[O].
Refraction Only in lieu of Routine Vision Examination for Covered Persons age 13 or older	Once every 24 months	To a maximum of a $0 allowance.	To a maximum of a $45 allowance[O].
CONTACT LENS FITTING AND EVALUATION	Once every 24 months		
Contact Lens Fitting and Evaluation		To a maximum of a $60 allowance.	To a maximum of a $0 allowance.
EYEGLASS FRAME[B1, G]	Once every 24 months		
Eyeglass Frame		Co-payment of $0[C] to a maximum of a $30 allowance.	To a maximum of a $30 allowance.
EYEGLASS LENSES[B1]	Once every 24 months		
Single Vision Lenses*		Co-payment of $0[C].	To a maximum of a $20 allowance.
Bifocal-lined Lenses		Co-payment of $0[C].	To a maximum of a $30 allowance.
Trifocal-lined Lenses		Co-payment of $0[C].	To a maximum of a $40 allowance.

SERVICE[M, K]	FREQUENCY OF SERVICE	NETWORK BENEFIT The Amount You Pay	OUT-OF-NETWORK BENEFIT
Lenticular Lenses		Co-payment of $0[C].	To a maximum of a $75 allowance.
OPTIONAL LENS EXTRAS [F]	Once every 24 months		
Standard Anti-Reflective Coating		Co-payment of $0.	To a maximum of a $0 allowance.
Standard Scratch Coating		Co-payment of $0.	To a maximum of a $0 allowance.
Oversize Lenses		80% of retail billed charge after a Co-payment of $0[C] toward Covered Eyeglass Lenses.	To a maximum of a $0 allowance.
Blended Bifocal Lenses		80% of retail billed charge after a Co-payment of $0[C] toward Covered Eyeglass Lenses.	To a maximum of a $0 allowance.
Tier One Progressive Lenses		After a Co-payment of $0[C] toward Covered Eyeglass Lenses and the lesser of $55 or retail billed charge.	To a maximum of a $0 allowance.
Tier Two Progressive Lenses		After a Co-payment of $0[C] toward Covered Eyeglass Lenses and the lesser of $100 or retail billed charge.	To a maximum of a $0 allowance.
Tier Three Progressive Lenses		After a Co-payment of $0[C] toward Covered Eyeglass Lenses and the lesser of $150 or retail billed charge.	To a maximum of a $0 allowance.
Tier Four Progressive Lenses		After a Co-payment of $0[C] toward Covered Eyeglass Lenses and the lesser of $200 or retail billed charge.	To a maximum of a $0 allowance.

SERVICE[M, K]	FREQUENCY OF SERVICE	NETWORK BENEFIT The Amount You Pay	OUT-OF-NETWORK BENEFIT
Tier Five Progressive Lenses		After a Co-payment of $0[C] toward Covered Eyeglass Lenses and the lesser of $250 or retail billed charge.	To a maximum of a $0 allowance.
Aspheric Lenses		80% of retail billed charge after a Co-payment of $0[C] toward Covered Eyeglass Lenses.	To a maximum of a $0 allowance.
Digital Single Vision Lenses		80% of retail billed charge after a Co-payment of $0[C] toward Covered Eyeglass Lenses.	To a maximum of a $0 allowance.
Polycarbonate for Dependent children up to age 19		Co-payment of $0.	To a maximum of a $0 allowance.
Cataract Lenses		80% of retail billed charge after a Co-payment of $0[C] toward Covered Eyeglass Lenses.	To a maximum of a $0 allowance.
Occupational Double Segment Lenses		80% of retail billed charge after a Co-payment of $0[C] toward Covered Eyeglass Lenses.	To a maximum of a $0 allowance.
CONTACT LENSES[B1]	Once every 24 months		
Contact Lenses		To a maximum of a $0 allowance.	To a maximum of a $0 allowance.
Necessary Contact Lenses[H]		Co-payment of $0.	To a maximum of a $210 allowance.
CHILD ONLY BENEFIT	Once every 24 months	$250 allowance towards eyeglasses (frames & lens) or contact lens for children under 18.	To a maximum of a $0 allowance.

[A1] The Frequency of Service will be increased for Vision Care Services where the following occurs: Replacement of Lenses and or Frame due to a.50 diopter or more change in prescription.

[B1]You are eligible to select only one of either eyeglasses (Eyeglass Lenses/or Eyeglass Lenses and Eyeglass Frame) or Contact Lenses. If you select more than one of these Vision Care Services, only one

service will be covered. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses.

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

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

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

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

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

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

[O]The Benefit for an Out-of-Network Routine Vision Examination and Refraction Only Services will be a combined maximum of $40 allowance.

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

All Vision Care Services and procedures follow the criteria specified in the Current Procedural Terminology (CPT) listing as defined by the American Medical Association.

Section 1: Covered Vision Care Services

When Are Benefits Available for Covered Vision Care Services?

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

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

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

- The amount you must pay for these Covered Vision Care Services (including any applicable deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Vision Care Services (including frequency and dollar limits on services and materials).

1. Routine Vision Examination

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

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

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

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

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

E. Pupil reaction to light and focusing;

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

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

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

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

J. Ophthalmoscopic exam of the internal eye;

K. Visual field testing;

L. Biomicroscopy;

M. Color vision testing;

N. Diagnosis/prognosis;

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

P. Specific recommendations.

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

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

2. Eyeglass Lenses

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

3. Eyeglass Frame

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

4. Optional Lens Extras

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

5. Contact Lenses

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

6. Necessary Contact Lenses

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

Contact lenses are necessary if the Covered Person has:

A. Keratoconus;

B. Anisometropia;

C. Irregular corneal/astigmatism;

D. Aphakia;

E. Facial deformity;

F. Corneal deformity;

G. Pathological myopia;

H. Aniseikonia;

I. Aniridia;

J. Post-traumatic disorders;

K. Post-cataract surgery without intraocular lens; or

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

7. Contact Lens Fitting & Evaluation

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

8. Virtual Visits

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

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

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

Benefits do not include email or fax.

Section 2: Exclusions and Limitations

The Plan Does Not Pay Benefits for Exclusions

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

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

Where Are Benefit Limitations Shown?

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

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

A. Non-prescription items (e.g. Plano lenses).

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

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 frame that have been lost or broken

G. Optional Lens Extras not listed in the *Schedule of Benefits.*

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

I. Missed appointment charges.

J. Applicable sales tax charged on Services.

K. Services that are not specifically covered by the Plan.

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

M. Any vision service covered under an Essential Health Benefit plan is not Covered under this Policy.

N. Any vision service rendered by the Plan Sponsor.

O. Intraocular lenses.

Section 3: When Coverage Begins

How Do You Enroll?

Eligible Persons must complete an enrollment form or enroll through an electronic enrollment system given to them by the Plan Sponsor. The Plan Sponsor will submit the completed forms to the Claims Administrator, along with any required contribution. The Plan will not provide Benefits for health care services that you receive before your effective date of coverage.

To enroll, call the Plan Sponsor within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. If you wish to change your benefit elections due to your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Plan Sponsor within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

Who Is Eligible for Coverage?

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

Eligible Person

Eligible Person usually refers to an employee of the Plan Sponsor who (or other person whose connection with the Plan Sponsor) meets the eligibility rules. When an Eligible Person enrolls, the Claims Administrator refers to that person as a Participant. For a complete definition of Eligible Person, Plan Sponsor and Participant, see *Section 9: Defined Terms*.

You are eligible to enroll in the Plan if you are a regular full-time employee who is scheduled to work at least 30 hours per week or a person who retires while covered under the Plan.

Eligible Persons must live within the United States.

An Eligible Person under the Plan Sponsor's Plan, must enroll as a Participant and not as a Dependent on another Eligible Person’s plan.

Once your properly completed enrollment request is received, coverage will begin on the date of employment and ending with the first calendar day of the calendar month coinciding with or following 60 consecutive days of employment. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.n another Eligible Person’s plan.

Dependent

Dependent generally refers to the Participant's spouse and children. When a Dependent enrolls, the Claims Administrator refers to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

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

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your lawful spouse; or
- Your Domestic Partner; and
- Any child or yours who is:

- Less than 26 years old.
- From 26 years until the end of the calendar year in which the child reaches the age of 30, provided the child is unmarried and does not have a dependent of his own, is a Florida state resident or a full-time or part-time student, and is not covered under a plan of their own or entitled to benefits under Title XVIII of the Social Security Act. UnitedHealthcare may require such proof at least once each year until the end of the calendar year in which he attains age 30; and
- Who is 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage. Proof of the child's condition and dependence may be required to be submitted to the plan as a condition of coverage after the date the child ceases to qualify above. However, if a claim is denied, proof must be submitted by the Employee that the child is and has continued to be mentally or physically handicapped.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

When Do You Enroll and When Does Coverage Begin?

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

Initial Enrollment Period

When the Plan Sponsor purchases coverage under the Plan from the Claims Administrator, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Plan. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

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

Coverage begins on the date identified by the Plan Sponsor. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible.

New Eligible Persons

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

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included. A newborn child will be covered for the first 31 days of life even if you fail to enroll the child. If you enroll the child after the first 31 days and by the 60th day after his birth, coverage will be offered at an additional premium. Coverage for an adopted child will become effective from the date of placement in your home or from birth for the first 31 days even if you fail to enroll the child. However, if you enroll the adopted child between the 31st and 60th days after his birth or placement in your home, coverage will be offered at an additional premium.

Your Dependents will be insured only if you are insured.

Newborn Children

Coverage for newborn children of an insured employee or the employee's covered family member begins from the moment of birth.

Coverage for a newborn child of a covered family member terminates when the child is 18 months old.

If notice of birth is given to the company within 30 days there is no premium charge for the initial 30 day period. If notice is given within 60 days of the birth of the child, the insurer may not deny coverage for a child due to the failure of the insured to timely notify the insurer of the birth of the child.

This policy covers newborn children for the necessary dental care or dental treatment of congenital defects or birth abnormalities of the teeth or gums.

Foster Children, Adoptive Children and Children in Custodial Care

Benefits applicable to children of the insured employee also apply to adoptive children, foster children and children in custodial care. Coverage begins from birth or from the moment of placement in the home. Coverage may not exclude any preexisting condition of the child.

In the case of a newborn adoptive child, coverage begins from the moment of birth if there is a written agreement to adopt the child, whether or not the agreement is enforceable.

Coverage does not extend to an adoptive child who is not ultimately placed in the home of the insured employee.

If notice of the birth or placement of an adopted child is given to the company within 30 days there is no premium charge for the initial 30 day period.

If notice is given within 60 days of the birth or placement of an adopted child, the insurer may not deny coverage for the child due to the failure of the insured to timely notify the insurer of the birth or placement of the child.

If any family member of the insured employee is covered as a dependent, then benefits applicable to children are covered with respect to a foster child or other child in court-ordered temporary custody or other custody of the insured employee.

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

If notice is given within 60 days of the birth of the child, the insurer may not deny coverage for a child due to the failure of the insured to timely notify the insurer of the birth of the child.

Adding New Dependents

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

Coverage for the Dependent, except for newborns, begins on the date of the event. The Plan Sponsor must receive the completed enrollment form and any required contribution within 31 days of the event. For newborns, coverage begins at the moment of birth if the newborn is enrolled by the Participant as described below. For newborns placed for adoption or foster care, coverage begins from the moment of birth if there is an agreement to place or adopt the newborn and the newborn is ultimately placed in the Participant's home. For newborns, adopted children and children placed for foster care, no contribution will be charged for the first 31 days if written notice to enroll the new dependent is given within 31 days of the event. If the Participant fails to enroll the new dependent within 31 days but does so within 60 days of the event, the Participant will be required to pay an additional contribution from the date of birth or placement. If written notice is not given within 60 days of birth or placement, the newborn, foster child or adopted child may be enrolled during any Open Enrollment Period.

Special Enrollment Period

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

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

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

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

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

- The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the Plan Sponsor receives the completed enrollment form and any required contribution within 60 days of the date of determination of subsidy eligibility.

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

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

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

Section 4: When Coverage Ends

General Information about When Coverage Ends

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

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

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

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Plan Ends**

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

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to Section 8: Defined Terms for definitions of the terms "Eligible Person," " Participant," "Dependent" and "Enrolled Dependent."

- **The Claims Administrator Receives Notice to End Coverage**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends on the last day of the calendar month in which the Claims Administrator receives the required notice from the Plan Sponsor to end your coverage, or on the date requested in the notice, if later.

- Participant **Retires or Is Pensioned**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends the last day of the calendar month in which the Participant is retired or receiving benefits under the Plan Sponsor's pension or retirement plan.

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

Fraud or Intentional Misrepresentation of a Material Fact

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

If the Claims Administrator and the Plan Sponsor find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact the Plan

Sponsor has the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

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. The Plan will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/herself because of mental, developmental or physical disability.
- The Enrolled Dependent child depends mainly on the Participant for support.

Coverage will continue as long as the Enrolled Dependent child is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Plan.

You must furnish the Plan Sponsor with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before the Plan Sponsor agrees to this extension of coverage for the child, we may require that a Physician examine the child. The Plan Sponsor will choose the Physician and the Plan will pay for that examination.

The Plan Sponsor may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical exams at the Plan's expense. The Plan Sponsor 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 days of the Plan Sponsor's request as described above, coverage for that child will end.

Section 5: How to File a Claim

How Are Covered Vision Care Services from Network Providers Paid?

The Claims Administrator processes payments to Network providers directly for your Covered Vision Care Services. If a Network provider bills you for any Covered Vision Care Service, contact the Claims Administrator. However, you are required to meet any applicable deductible and to pay any required Copayments and/or Coinsurance to a Network provider. You will also be responsible for any charges that are not Covered by the Plan to your Vision Provider.

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

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

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

Required Information

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

- The Covered Person's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- An itemized bill from your provider that includes a description of each charge.

The above information should be filed with the Claims Administrator at Claims Department, P.O. Box 30978, Salt Lake City, UT 84130 or by fax to 248-733-6060. If you would like to use a claim form, you may access a form on the Internet at www.myuhcvision.com or call the Claims Administrator at the telephone number shown on your ID card and a claim form will be provided to you.

Payment of Benefits

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Policy to an out-of-Network Vision Plan without the Claims Administrator's consent. When an assignment is not obtained, the Claims Administrator will send the reimbursement directly to the Participant for reimbursement to an out-of-Network provider. The Claims Administrator reserves the right, in its discretion, to process Plan payment to an out-of-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to an out-of-Network Vision Provider, the Plan has the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan.

When you assign your Benefits under the Plan to an out-of-Network Vision Provider with the Claims Administrator's consent, and the out-of-Network Vision Provider submits a claim for payment, you and the out-of-Network Vision Provider represent and warrant the following:

- The Covered Vision Care Services were actually provided.
- The Covered Vision Care Services were appropriate.

When the Claims Administrator has not consented to an assignment, the Claims Administrator will send the reimbursement directly to you (the Participant) for you to reimburse the provider upon receipt of their bill. However, the Claims Administrator reserves the right, in its discretion, to pay the provider directly for services rendered to you. When exercising its discretion with respect to payment, the Claims Administrator may consider whether you have requested that payment of your Benefits be made directly to the provider. Under no circumstances will the Claims Administrator pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a provider shall not be deemed to constitute consent by the Claims Administrator to an assignment or to waive the consent requirement. When the Claims Administrator in its discretion directs payment to a provider, you remain the sole beneficiary of the payment, and the provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, the Claims Administrator may in its discretion send information concerning the Benefits to the provider as well. If payment to a provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to Refund of Overpayments in *Section 8: General Legal Provisions*.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in a form of other consideration that we determine to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of the amount the provider owes us, or to other plans for which we make payments where we have taken an assignment of the other plans' recovery rights for value.

Obtaining Services

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

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

Foreign Services

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

Section 6: Questions, Complaints and Appeals

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

What if You Have a Question?

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

What if You Have a Complaint?

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

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

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

How Do You Appeal a Claim Decision?

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact the Claims Administrator in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical 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 the Claims Administrator within 180 days after you receive claim denial.

Appeal Process

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

Appeals Determinations

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

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

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

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

Type of Claim or Appeal	Timing
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial claim is complete, within:	30 days
• after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

Section 7: General Legal Provisions

What Is Your Relationship with the Claims Administrator and Plan Sponsor?

It is important for you to understand the Claims Administrator's role with respect to the Plan and how it may affect you. The Claims Administrator helps administer the claims payment for the Plan Sponsor's Plan in which you are enrolled. The Claims Administrator and the Plan Sponsor do not provide vision services or make treatment decisions. This means:

- The Claims Administrator communicates to you decisions about whether the Plan will cover or pay for the vision care that you may receive. The Plan pays for Covered Vision Care Services, which are more fully described in this *SPD*.
- The Plan may not pay for all vision services or materials you or your Vision Provider may believe are needed. If the Plan does not pay, you will be responsible for the cost.

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

Please refer to the Claims Administrator *Notice of Privacy Practices* for details.

What Is the Claims Administrator's Relationship with Providers and Plan Sponsors?

The relationships between the Claims Administrator and Network Vision Providers and Plan Sponsors are solely contractual relationships between independent contractors. Network Vision Providers and Plan Sponsors are not the Claims Administrator's agents or employees. Neither the Claims Administrator nor any of the Claims Administrator's employees are agents or employees of Network Vision Providers or the Plan Sponsors.

Plan Sponsors and the Claims Administrator do not provide vision care services or materials. The Plan Sponsors and the Claims Administrator arrange for vision providers to participate in a Network and the Claims Administrator processes the Plan's payment of Benefits. Network Vision Providers are independent practitioners who run their own offices and facilities. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. Network Providers are not the Plan Sponsor's employees, Network providers are not the Claims Administrator's employees. The Plan Sponsor and the Claims Administrator do not have any other relationship with Network vision providers such as principal-agent or joint venture. The Plan Sponsor and the Claims Administrator are not responsible for any act or omission of any vision provider.

The Claims Administrator is not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Plan. The Claims Administrator is not responsible for fulfilling any duties or obligations of an employer with respect to the Plan.

The Plan Sponsor is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Plan's Service Fee to the Claims Administrator.

- The funding of Benefits on a timely basis.
- Notifying you of when the Plan ends.

What Is Your Relationship with Providers and Plan Sponsors?

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

You are responsible for all of the following:

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

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

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

Notice

When the Claims Administrator provides written notice regarding administration of the Plan to an authorized representative of the Plan Sponsor, that notice is deemed notice to all affected Participants and their Enrolled Dependents. The Plan Sponsor is responsible for giving notice to you.

How Does the Plan Use Headings?

The headings, titles and any table of contents contained in the SPD or Schedule of Benefits are for reference purposes only and shall not in any way affect the meaning or interpretation of the SPD or Schedule of Benefits.

Statements by the Plan Sponsor or Participants

All statements made by the Plan Sponsor or by a Participant shall, in the absence of fraud, be deemed representations and not warranties. The Claims Administrator will not use any statement made by the Plan Sponsor to void the Plan after it has been in force for two years unless it is a fraudulent statement.

Are Incentives Available to You?

Sometimes the Claims Administrator may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including wellness programs, certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is yours alone. However, the Claims Administrator recommends that you discuss taking part in such programs with your Vision Provider. Contact the Claims Administrator at www.myuhcvision.com or telephone at 1-800-638-3120 if you have any questions.

Who Interprets Benefits and Other Provisions under the Plan?

The Plan Sponsor and the Claims Administrator have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions set out in the Plan, including this *SPD*, the *Schedule of Benefits* and any Summary Material Modifications (SMM), Addendums and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

The Plan Sponsor and the Claims Administrator may, in its discretion, assign this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

Who Provides Administrative Services?

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

What is the Future of the Plan?

Although the Plan Sponsor expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code, or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and the Plan Sponsor's decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Plan Sponsor and others as may be required by any applicable law

Amendments to the Plan

To the extent permitted by law, the Plan Sponsor has the right, as it determines and without your approval, to change, interpret, withdraw or add Benefits or end the Plan.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of applicable state law provisions not otherwise preempted by federal statutes or regulations (of the jurisdiction in

which the Plan is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Plan unless it is made by an Amendment or SMM. All of the following conditions apply:

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

How Does the Claims Administrator Use Information and Records?

The Claims Administrator may use your individually identifiable health information as follows:

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

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

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Claims Administrator with all information or copies of records relating to the services provided to you. The Claims Administrator has 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 Participant's enrollment form. The Claims Administrator agrees that such information and records will be considered confidential.

The Claims Administrator has the right to release records concerning vision care services when any of the following apply:

- Needed to put in place and administer the terms of the Plan.
- Needed for review or quality assessment.
- Required by law or regulation.

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

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

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

In some cases, as permitted by law, the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as needed. The

Claims Administrator's designees have the same rights to this information as the Claims Administrator has.

Does the Plan Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, the Plan Sponsor may require that a Network Vision Provider of its choice examine you at the Plan's expense.

Is Workers' Compensation Affected?

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

Subrogation and Reimbursement

The Plan has the right to subrogation and reimbursement. References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- Your employer in a workers' compensation case or other matter alleging liability.
- 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 against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying us, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.

- Signing and/or delivering such documents as the Plan or the Plan's agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining the Plan's consent or the Plan's agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has have a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan has first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan has subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits under the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Plan with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.

- The Plan's right to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any benefits, claims or rights of recovery you have under any automobile policy - including no-fault benefits, PIP benefits and/or medical payment benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, its our option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; f judgment or other recovery from any third party considered responsible; and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without the Plan's written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of the Plan's interest unless the Plan provides written consent to the allocation.
- 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 any third party. If a parent or guardian brings a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the Participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of the Plan's discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

When Does the Plan Receive Refunds of Overpayments?

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

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

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

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

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

Is There a Limitation of Action?

You cannot bring any legal action against the Plan or the Claims Administrator to recover reimbursement until you have completed all the steps in the appeal process described in Section 6: Questions, Complaints and Appeals. After completing that process, if you want to bring a legal action against the Plan or the Claims Administrator you must do so within three years of the date the Plan or the Claims Administrator notified you of its final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator.

What Is the Entire Plan?

The Plan, this *SPD*, the *Schedule of Benefits*, the Group's *Application* and any SMMs, Addendums and/or Amendments, make up the entire Plan.

Section 8: Defined Terms

Addendum - any attached written description of additional or revised provisions to the Plan. The Benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

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

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

Claims Administrator - the organization that provides certain claim administration and other services for the Plan.

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

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

Covered Person - the Participant or a Dependent, but this term applies only while the person is enrolled under the Plan. The Plan Sponsor uses "you" and "your" in this *SPD* to refer to a Covered Person.

Covered Vision Care Service(s) - vision care services which the Claims Administrator determines to be all of the following:

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

Dependent - the Participant's legal spouse or a child of the Participant or the Participant's spouse. As described in *Section 3: When Coverage Begins*, the Plan Sponsor determines who is eligible to enroll and who qualifies as a Dependent. The term "child" includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child placed for foster care.
- A newborn child from the moment of birth, if a written agreement to adopt the child has been entered into by the Participant prior to the birth of the child.
- A child for whom legal guardianship has been awarded to the Participant or the Participant's spouse.
- A child for whom vision care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Plan Sponsor is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

The following conditions apply:

- A Dependent includes a child listed above under age 30.

- In the event that the Participant has an unmarried Dependent who meets the following requirements, extended coverage is available for that Dependent up to the age of 30. Contact your Plan Sponsor for details. To be eligible for extended coverage, a Dependent must satisfy the following:
    - Does not have dependent of his or her own;
    - Is a resident of Florida or a Student, and
    - Does not have coverage as a named subscriber, insured, enrollee or covered person under any other group, blanket or franchise vision policy or individual vision benefits plan, or is not entitled to benefits under *Title XVIII of the Social Security Act*

A child who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the month following the date the child reaches age 30.

The Participant must reimburse the Plan for any Benefits paid during a time a child did not satisfy these conditions.

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

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Vision Care Services through live audio with video technology or audio only.

Domestic Partner - a person of the opposite or same sex with whom the Participant has a Domestic Partnership.

Domestic Partnership - a relationship between a Participant and one other person of the opposite or same sex. All of the following requirements apply to both persons. They must:

- Not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Both parties consent to the domestic partnership relationship without force, duress or fraud.
- Share the same permanent residence and the common necessities of life.
- Be at least 18 years of age.
- Both parties agree to be jointly responsible for each other’s basic food, shelter, common necessities of life and welfare.
- Each party considers himself/herself to be a member of the immediate family of the other partner.
- Not part of another Domestic Partnership for the past 12 months.

The Participant and Domestic Partner must jointly sign the required affidavit of Domestic Partnership and have registered as Domestic Partners, if you reside in a County that provides for such registration.

Eligible Person - an employee of the Plan Sponsor or other person connected to the Plan Sponsor who meets the eligibility requirements shown in the Plan. An Eligible Person must live within the United States.

Enrolled Dependent - a Dependent who is properly enrolled under the Plan.

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

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

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

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

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

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

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

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

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

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

Participant - an Eligible Person who is properly enrolled under the Plan. The Participant is the person (who is not a Dependent) on whose behalf the Plan is issued to the Plan Sponsor and who meets the eligibility requirements specified in the Plan. A Participant must live and/or work in the United States.

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

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

Plan - the Plan Sponsor's Self-Funded group vision benefit plan.

The "What Is the Summary Plan Description?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

Plan Sponsor - the employer, or other defined or otherwise legally established group, to whom the Plan is issued. The "What Is the Summary Plan Description?" provision of the SPD will tell you who the Plan Sponsor of this Plan is.

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