UnitedHealthcare Vision

UnitedHealthcare Insurance Company

Certificate of Coverage

For

Abel HR, Inc.

GROUP NUMBER: 905975

EFFECTIVE DATE: November 1, 2018

UnitedHealthcare Insurance Company

Vision Certificate of Coverage

Issued To:	Abel HR, Inc. (''Enrolling Group'')
Policy Number:	905975
Policy Effective Date:	November 1, 2018
Policy Anniversary Date:	November 1

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 New Jersey.

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 authority to make an initial interpretation of 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. Such interpretation can be reversed by an internal utilization review organization, a court of law, or an arbitrator of administrative agency having jurisdiction. 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 required 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 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 civil union partner. All references to the spouse of a Subscriber shall include a Domestic Partner. or (2.) a Dependent child of the Subscriber or the Subscriber's spouse or civil union partner (including a natural child, stepchild, a legally adopted child, a child placed for adoption, or a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse). 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. The Enrolling Group is 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.

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has established a Domestic Partnership. In no event will a person's legal spouse be considered a Domestic Partner.

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

- Both persons have a common residence and are otherwise jointly responsible for each other's common welfare as evidenced by joint financial arrangements or joint ownership of real or personal property, which shall be demonstrated by at least one of the following:

  (a) a joint deed, mortgage agreement or lease;

  (b) a joint bank account;

(c) designation of one of the persons as a primary beneficiary in the other person's will;

d) designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or

(e) joint ownership of a motor vehicle;

- Both persons agree to be jointly responsible for each other's basic living expenses during the domestic partnership;
- Neither person is in a marriage recognized by New Jersey law or a member of another domestic partnership;
- Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;
- Both persons are of the same sex and therefore unable to enter into a marriage with each other that is recognized by New Jersey law, except that two persons who are each 62 years of age or older and not of the same sex may establish a domestic partnership if they meet the requirements set forth in this section;
- Both persons have chosen to share each other's lives in a committed relationship of mutual caring;
- Both persons are at least 18 years of age;
- Both persons file jointly an affidavit of Domestic Partnership; and
- Neither person has been a partner in a Domestic Partnership that was terminated less than 180 days prior to the filing of the current affidavit of Domestic Partnership, except that this prohibition shall not apply if one of the partners died; and, in all cases in which a person registered a prior domestic partnership, the domestic partnership shall have been terminated in accordance with the provisions of section 10 of P.L.2003, c.246 (C.26:8A-10).

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.

Essential Health Benefits - pediatric vision care services included as Essential Health Benefits as set forth in the Patient Protection and Affordable Care Act.

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.

Medicare - Parts A, B, and C 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 - the collective group of Vision Providers 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. Covered Vision Services provided by a Non-Network provider are considered Network Benefits when such services are for Emergency Care.

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.

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

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.

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.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

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 or during an Open Enrollment 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 of the month following any applicable waiting period required by the Enrolling Group.

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, civil union, or marriage will take effect on the date of the event. Coverage for a newborn child is provided for 31 days and if payment of additional premium is required to provide coverage for the child, we must be furnished the required premium and be notified of the birth within 31 days after the birth in order to have the Coverage continue beyond the 31 day period. Coverage for all other new Dependents is effective only if we are furnished any required Premium and are notified of the event within 31 calendar days.

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. Otherwise, you will need to wait until the next annual Open Enrollment Period.

Special Enrollment Period

An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period or Open Enrollment 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 or Open Enrollment 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.

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 31 calendar days 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.

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 last day of the calendar month in which you cease to be eligible as a Subscriber, Enrolled Dependent or active member of the Policyholder.

C. The end of the month 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.

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.

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 handicap 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.

Extended Coverage for Total Disability

A temporary extension of Coverage, only for treatment of the condition causing a Total Disability, will be granted to a Covered Person who is Totally Disabled on the date the person's Coverage is terminated due to termination of the entire Policy. Benefits will be Covered until (a) the Total Disability ends or (b) 90 days from the date the Policy terminated, whichever is less. Such benefits are subject to the terms and conditions of the Policy.

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*.

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

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.

When obtaining Vision Services from a Non-Network Vision Provider, you will be required to pay all billed charges to your Vision Provider. You may then obtain reimbursement 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.

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 service(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).
- Any other information requested by Us.

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 should be given to us within 90 calendar days after the date of the loss. If it was not reasonably possible to give written proof in the time required, we will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible.

Notice of Claim

Notice of claim as determined by us must be given to us within 365 days of the date such loss begins. The notice must be given with sufficient information to identify the Covered Person. Failure to file such notice within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, the notice must be given as soon as reasonably possible.

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.

How to Appeal a Claim Decision

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.

If you are not satisfied with our decision, you have the right to take your complaint to the

Division of Insurance

Enforcement and Consumer Complaints

PO Box 329

Trenton NJ 08625-0329

1-800-446-7467 (in New Jersey

609-292-5319

Department of Health and Senior Services

Office of Managed Care

PO Box 360

Trenton NJ 08625-0360

609-633-0660.

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, which is attached to the Policy, Amendments and Riders, constitute the entire Policy. All statements made by the Enrolling Group or by a Subscriber will be deemed representations and not warranties. No such statement shall void or reduce Coverage under the Policy or be used in defense of a legal action unless it is contained in a written application signed by the Enrolling Group or by a Subscriber, as applicable.

Time Limit on Certain Defenses

No statement, except a fraudulent statement, made by the Enrolling Group will be used to void the Policy after it has been in force for a period of 2 years.

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 executive officer of the Company and the Enrolling Group. 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.

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.

Refund of Overpayments

If we pay benefits for expenses incurred on account of you, that were paid to you, you must make a refund to us if any of the following apply:

- 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.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 5: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal.

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;

P. Specific recommendations; and

Q. Any other related services as designated by us.

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;

F. Corneal deformity; or

G. Any other condition we designate.

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.

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.

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 $0.00	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
Eyeglass Frames[A]	Once every 12 months	After a Copayment of $0.00[B] To a maximum of a $150.00 allowance	To a maximum of a $45.00 allowance
Eyeglass Lenses[A]	Once every 12 months		
Single Vision*		After a Copayment of $0.00[B]	To a maximum of a $40.00 allowance
Bifocal-lined		After a Copayment of $0.00[B]	To a maximum of a $60.00 allowance
Trifocal-Lined		After a Copayment of $0.00[B]	To a maximum of a $80.00 allowance
Lenticular		After a Copayment of $0.00[B]	To a maximum of a $80.00 allowance
Optional Lens Extras	Once every 12 months		
Polycarbonate for Dependent children up to age 19		After a Copayment of $0.00	
Contact Lenses[A]	Once every 12 months	After a Copayment of $0.00 for up to 6 boxes from the Covered Contact Lens Selection.[C] To a maximum of a	To a maximum of a $150.00 allowance

SERVICE	FREQUENCY OF SERVICE	NETWORK BENEFIT	NON-NETWORK BENEFIT
		$150.00 allowance if not from the Covered Contact Lens Selection.[C]	
Necessary Contact Lenses[A]	Once every 12 months	After a Copayment of $0.00	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 and/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. ET.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-800-638-3120។

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

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

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

Notice of Non-Discrimination

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

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

Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance

P.O. Box 30608

Salt Lake City, UT 84130

UHC_Civil_Rights@uhc.com

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

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

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

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

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

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

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

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

Claims and Appeal Notice

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

How to Request an Appeal

If you disagree with 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.

VISION PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

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

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 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 related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular 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 enrollees' 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 purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

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

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

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

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

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

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

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

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

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

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

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

- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal 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, and pursuant to federal law, 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 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 your vision plan ID card or you may contact a *UnitedHealth Group Customer Call Center* Representative at 1-800-638-3120, or TTY 711.

- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare

Vision HIPAA - Privacy Unit

PO Box 30978

Salt Lake City, UT 84130

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

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

[2]*This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: UnitedHealthcare Insurance Company and UnitedHealthcare Insurance Company of New York.*

FINANCIAL INFORMATION PRIVACY NOTICE

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

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, 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 communications on our behalf.

Confidentiality and Security

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

Questions about this Notice

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

[3]*For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the 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:

1. show the categories of health information that are subject to these more restrictive laws; and
2. 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, 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.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, OH, WA, 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, UT, VT
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, NC, NH, NM, NV, NY, 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	WA

who is the subject of the information.	
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, AR, CO, IL, LA, MD, 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*.

ERISA Statement

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

Summary Plan Description

Name of Plan: Abel HR, Inc. Welfare Benefit Plan

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

Abel HR, Inc.
2 Corporate Drive
Cranbury, NJ 08520
(609) 860-0400

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

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

Employer Identification Number (EIN): 22-3163382

Plan Number: 501

Plan Year: November 1 through October 31

Type of Plan: Health care coverage plan

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

Abel HR, Inc.
2 Corporate Drive
Cranbury, NJ 08520
(609) 860-0400

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

UnitedHealthcare
185 Asylum Street
Hartford, CT 06103-0450
860-702-5000

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

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made 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.