

**STATE OF GEORGIA FLEXIBLE  
BENEFITS PROGRAM**

OptumHealth Vision Insurance

Effective January 1, 2011

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**Notice Regarding Provider Directories and Provider Networks**

Since your Plan utilizes a network of Providers, You may contact 1-800-839-3242 or visit [www.myoptumhealthvision.com](http://www.myoptumhealthvision.com) to obtain the name of a Participating Provider.

**OptumHealth Vision**

A UnitedHealth Group Company certifies that it insures certain Employees for the benefits provided by the following policy(s) No. 2800:

**POLICYHOLDER:** The State of Georgia

**EMPLOYER:** State Personnel Administration

**Employer Account No.** 2800

This summary booklet describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This summary booklet takes the place of any other booklet issued to you on a prior date which described the insurance.

## **Explanation of Terms**

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

## **EFFECT OF SECTION 125 REGULATIONS ON THIS PLAN**

Your Employer has chosen to administer this Plan in accordance with Section 125 Regulations of the Internal Revenue Code. Per this regulation, you may agree to a pre-tax salary reduction put toward the cost of your benefits.

Provisions in this certificate which allow for enrollment or coverage changes not consistent with Section 125 Regulations are superseded by this section.

## **COVERAGE ELECTIONS**

Per Section 125 Regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period unless your experience a qualified life event. If you experience a life event that would allow a change in coverage, you must request a change in your coverage within thirty (30) days of the life event by contacting GaBreeze at 1-877-342-7339.

## **ELIGIBILITY**

### **Eligibility for Employee Insurance**

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees;
- you are a full-time Employee of the State of Georgia, or a State Agency, working at least 30 hours per week, on a continuous basis, and whose employment is expected to last at least nine (9) months, or
- you are a public school teacher who is employed in a professionally certificated capacity, working 17.5 hours or more per week, or
- you are the Employee of a local school system who holds a non-certificated position and is eligible to participate in the Teachers Retirement System and working at least 20 hours a week or 60% of the time necessary to carry out the duties of the position, if that is more than 20 hours per week, or
- you are an Employee who is eligible to participate in the Public School Employee Retiree System and who works at least 15 hours per week or 60% of the time necessary to carry out the duties of the position, if that is more than 15 hours per week, or
- you are an Employee of a county or regional library and working 17.5 hours or more, and
- others deemed eligible by Federal or Georgia Law.

### **Eligibility for Dependent Insurance**

Your dependent will become eligible for Dependent insurance on the later of:

- The day you become eligible for coverage yourself; or
- The day you acquire your first Dependent.

### **Waiting Period**

The first of the month following one full calendar month of employment.

## **ELIGIBILITY — EFFECTIVE DATE**

### **Coverage Effective Date**

Your coverage under the policy shall become effective on the latter of:

- The date of eligibility provided you are Actively at Work. If you are not Actively at Work on that day, the coverage will begin:
  - The day that you return to work; or
  - On the date of eligibility if it is your scheduled day off and that you were Actively at Work on the preceding scheduled workday.
- First day of the Plan Year, provided you are Actively at Work, following the initial Annual Enrollment Period; or
- First day of the Plan Year, provided you are Actively at Work, following any Annual Enrollment Period subsequent to the initial Annual Enrollment Period.
- For new hires, on the first day of the calendar month following one full month of employment.

If you enroll for dependent coverage on your eligibility date, insurance for your eligible Dependents shall be effective on the same date as the effective date of your insurance.

If you acquire a dependent after enrollment, you may add them to coverage within the timeframe allowed under “Life Event” and their coverage will be effective the first of the month after adding them.

## **ELIGIBILITY — Enrolling for Coverage**

### **Annual Enrollment Period**

Annual Enrollment Period means an annual enrollment period specified by the State Personnel Administration during which you have an opportunity to enroll or change coverage.

### **Choice of Participating Vision Care Provider**

When you elect vision Insurance, you may utilize any Participating Vision Care Provider from the list provided by OptumHealth Vision.

You and each of your insured Dependents may select your own designated Participating Vision Care Provider.

### **REQUIREMENTS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA'93)**

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, as amended, where applicable.

#### **A. Eligibility for Coverage under a Qualified Medical Child Support Order**

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order.

You must notify your Employer and elect coverage for that child and yourself if you are not already enrolled, within 30 days of the Qualified Medical Child Support Order being issued.

#### **Qualified Medical Child Support Order**

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- (1) the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- (2) the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- (3) the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- (4) the order states the period to which it applies; and
- (5) if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with State laws regarding child health care coverage.

### **Payment of Benefits**

Any payment of benefits in reimbursement for Covered Expenses paid by the child, the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a State official whose name and address have been substituted for the name and address of the child.

### **B. Eligibility for Coverage for Adopted Children**

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all vision coverage ceases when the placement ends, and will not be continued.

## **VISION BENEFITS – OPTUMHEALTH VISION CARE**

### **How the Plan Works**

When you are ready to obtain vision care services, call your OptumHealth Vision participating provider. If you need to locate an OptumHealth Vision participating provider, visit OptumHealth's Vision Web site at [www.myoptumhealthvision.com](http://www.myoptumhealthvision.com), or call OptumHealth's Vision provider locator at (800) 839-3242.

When making an appointment, identify yourself as an OptumHealth Vision member. The participating provider will also need the primary insured's Social Security Number, and the primary insured's group name. The participating provider will contact OptumHealth Vision to verify that you are eligible for service and materials.

While an ID Card is not needed to secure services, you may wish to go to the website [www.myoptumhealthvision.com](http://www.myoptumhealthvision.com) and print one. Simply log in with your ID, date of birth, etc. and click the "print an ID Card" button. For dependents, log in with your ID but enter their date of birth to print a card with their name on it.

At your appointment, the participating provider will provide an eye examination and determine if eyewear is necessary. If so, the participating provider will coordinate the prescription with an OptumHealth Vision-approved, contract laboratory. The participating provider will itemize any non-covered charges and have you sign a form to document that you received services. OptumHealth Vision will pay the participating provider directly for covered services and materials.

You are responsible for paying the provider any applicable copayment(s), and any additional costs resulting from cosmetic options, or non-covered services and materials you have selected. Selecting a participating provider from OptumHealth Vision's network assures direct payment to the provider and helps to insure quality services and materials.

## Plan Options

There are two plan Options: The Select Plan Option and the Select Plus Plan Option.

Under the Select Plan Option, the plan covers in-full, a pair of standard single, lined bifocal or multifocal lenses, when received from a participating provider. Standard scratch resistant coating is provided.

Under the Select Plus Plan Option, the plan covers in-full, a pair of standard single, Basic Progressive bifocal or multifocal lenses, when received from a participating provider. In addition, Tints, UV and Polycarbonate lenses are covered as well as the standard scratch resistant coating.

The Copayments are:	Select Option	Select Plus Option
Exam copay	\$10	\$10
Materials copay	\$20	\$25

## Covered Benefits

Standard Eye Examination includes:

- Case History of Patient
- Examination for Eye Pathology and Abnormalities
- Visual Analysis (Refraction)
- Diagnosis and Prescription
- Visual Skill Testing

### Frequency

Eye examination: Once each 12 months\*

Spectacle Lenses: Once each 12 months\*

Frame: Once each 24 months\*

*\*from your last date of service*

### Spectacle Lenses and Frames

OptumHealth Vision covers a wide selection of frames, but not all frames will be covered-in-full. When a patient selects a frame that exceeds the plan's allowance, these additional charges are administered at controlled costs. OptumHealth Vision also has controlled costs for cosmetic options, and these charges are typically less than usual and customary fees. Please consult your participating provider about lens options which may be cosmetic in nature, and may result in additional charges.

Elective or Necessary contact lenses may be provided instead of glasses.

### **Contact Lenses**

OptumHealth Vision covers a wide variety of contact lenses in-full, when obtained from a participating provider location. If you elect contact lenses outside of OptumHealth's Vision covered selection, you will receive an allowance of **\$105 under the Select Plan Option** or an allowance of **\$125 under the Select Plus Plan Option** toward the usual retail cost of the dispensing, fitting and materials. Any amount over the allowance is the patient's responsibility.

The frequency for contacts is the same as spectacle lenses. Under this plan, if you elect contact lenses, you will be eligible for a frame 12 **months after** the last date of obtaining the contact lenses.

### **Necessary Contact Lenses**

OptumHealth Vision covers necessary contacts lenses in full when prescribed by a participating provider for one of the following conditions:

- Following cataract surgery;
- To correct extreme vision problems that cannot be corrected with spectacle lenses;
- With certain conditions of anisometropia; or
- With certain conditions of keratoconus.

OptumHealth Vision recommends that the participating provider verify that necessary contact lenses are appropriate before submitting the claim.

### **Non-Participating Provider**

You may select any licensed vision care provider for services. Your reimbursement schedule may not provide full payment, nor can OptumHealth Vision help to insure patient satisfaction, when services are obtained from a non-participating provider.

### **General Claims Filing**

In general, in-network providers handle the claims process for you. If you receive services and/or materials out-of-network, however, you will have to pay the provider and seek reimbursement through the claims process. Claims must be filed no later than 12 months from the date of service. Claims will generally be paid within 30 days of receipt. For reimbursement for out-of-network services, you must submit receipts to OptumHealth's Vision Claims department via facsimile number 248-733-6060 or via mail to: OptumHealth Vision Claims Department, P. O. Box 30978, Salt Lake City, UT 84130. Receipts for services received together must be submitted together. Receipts for services and materials purchased on different dates must be submitted together.

Follow these steps if you obtain services and/or materials from a non-participating provider:

- Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the eye examination, lens type, and frame.
- Send a copy of the itemized bill(s) to OptumHealth Vision.

The following information **must** also be included in your documentation.

- Primary Insured's name and mailing address;
- Primary Insured's Social Security number;
- Primary Insured's employer or group name; and
- Patient's name, relationship to member, and date of birth.

If you choose a Non-Network Provider, you will need to send your itemized receipts, with the primary-insured's Social Security number and the patient's name and date of birth to:

**OptumHealth's Vision Claims Department  
P. O. Box 30978  
Salt Lake City, UT 84130**

Please note: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.

### **Plan Limitations**

The Select Plan Option is designed to cover your vision needs rather than cosmetic materials. If you select any of the following, you will be responsible for an additional charge:

- Blended lenses;
- Oversize lenses;
- Progressive multifocal lenses;
- Photochromic or tinted lenses other than Pink 1 or 2;
- Coated or laminated lenses;
- Cosmetic lenses;

- A frame that exceeds the plan allowance;
- Certain limitations on low vision care;
- Optional cosmetic processes; or
- UV protected lenses.

Under the Select Plus Plan Option you are entitled to Basic Progressive lenses, Tints, UV and Polycarbonate lenses. If you select any additional services, you will be responsible for an additional charge:

The following professional services or materials are not covered. Discounts may apply to some items.

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses (non-prescription)
- Two pair of glasses in lieu of bifocals;
- Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment; or
- Corrective vision services, treatments, and materials of an experimental nature.

**This is only a summary. It does not waive or alter any of the terms of the policy. If questions arise, the policy will govern.**

### **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 any rights you may have under the Employee Retirement Income Security Act of 1974 (ERISA) or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about any rights and responsibilities you may have under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

## **COORDINATION OF BENEFITS**

Under this vision plan Coordination of Benefits rules do not apply.

## **MISCELLANEOUS**

Certain Participating Vision Facilities may provide discounts on services not listed on the Patient Charge Schedule, including a discount on Lasik services. You should contact your Participating Vision Facility to determine if such discounts are offered.

## **TERMINATION OF INSURANCE - EMPLOYEES**

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day of the calendar month following the month for which you have made any required contribution for the insurance.
- the date the policy is canceled.

Any continuation of insurance must be based on a plan which precludes individual selection.

## **Temporary Layoff or Leave of Absence**

On the date you are no longer Actively at Work except that:

- while you are sick or injured, and in an approved leave without pay period, your employment will be deemed to continue for up to 12 months from the date your disability began, as long as premium payments are made on your behalf; and
- while you are on an approved leave of absence (except a leave of absence to enter military or naval service), your employment will be deemed to continue, as long as premium payments are made, for up to 12 months, unless your Employer cancels your insurance before the end of that time.

## **Retirement (for Vision Insurance)**

If your Active Service ends because you retire, your insurance will be discontinued.

## **TERMINATION OF INSURANCE - DEPENDENTS**

Your insurance for your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day of the calendar month following the month for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.
- the date upon a determination of fraud or misuse of vision services and/or vision facilities.

The insurance for any one of your Dependents will cease on the end of the month during which the date that Dependent no longer qualifies as a Dependent occurs.

## **NOTICE OF FEDERAL REQUIREMENTS UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)**

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absence. These requirements apply to medical, dental and vision coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage.

### **Continuation of Coverage**

You may choose to discontinue vision coverage while on Military Leave, or continue coverage through personal premium payments. You may pay personal premium payments as long as you are on the Military Leave. Since both the commencement and completion of Military Leave is considered a Life Event, you may also select a different vision option at these times.

If you do not continue coverage through personal premium payments, upon return to employment, you will be reinstated for the type of vision coverage for which you enrolled prior to activation, unless a different option is selected. No penalties for non-payment will be applied.

The administration of the vision benefit described above is based on returning to work during the same plan year that you were placed on Military Leave. If you return in a different plan year, you are to be provided a thirty (30) day Annual Enrollment Period for the new plan year. You are guaranteed coverage for benefits in effect prior to the onset of your Military Leave.

If a qualifying Life Event occurs while on Military Leave, you are to report the Event upon return to active pay status. If you do not report the Event at that time, it should be reported within the allowable timeframe. Generally, a request for an

increase in coverage must be made within thirty (30) days; a request for a decrease in coverage must be made within thirty (30) days.

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence. For leaves of 31 days or more, you may continue coverage for yourself and your Dependent as follows:

Since your Employer is subject to federal continuation requirements called COBRA, you may continue benefits according to the federal continuation benefits shown in your certificate.

Following continuation of health coverage per COBRA or USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

## **NOTICE OF FEDERAL REQUIREMENTS UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)**

### **Reinstatement of Benefits (applicable to all coverages)**

If your coverage ends during the leave because you do not elect COBRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated.

### **CONTINUATION COVERAGE RIGHTS UNDER COBRA**

This notice will contain important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage.

This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under COBRA you should contact GaBreeze at 1-877-342-7339.

### **COBRA Continuation Coverage**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced, or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because one of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because one of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced; or
- (6) The child stops being eligible for coverage under the plan as a "dependent child, upon attainment of age 26.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Program Administrator has been timely notified that a qualifying event has occurred. Please contact GaBreeze at 1-877-342-7339 to advise of an event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or a dependent child losing

eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. The cost of coverage is 102% of the premium.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are several ways in which this 18-month period of COBRA continuation coverage can be extended. The cost of coverage for the 18 month period is 102% of the premium.

#### **Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The cost of the additional 11 months is 150% of the premium. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must contact GaBreeze at 1-877-342-7339 to advise of the disability. Your notice must address the determination of disability by the Social Security Administration and the date it happened. In the disability determination if these procedures are not followed or **if the notice is not provided in writing to the Program Administrator within the required 60-day period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO THE DETERMINATION OF DISABILITY BY THE SOCIAL SECURITY ADMINISTRATION.**

#### ***Second qualifying event extension of 18-month period of continuation coverage***

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, or gets divorced. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. The Plan requires you to follow the procedures specified in the box above, entitled "Notice Procedures." Your notice must also name the second qualifying event and the date it happened. In the second qualifying event **if these procedures are not followed or if the notice is not provided in writing to the Program Administrator within the required 60-day period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO THE SECOND QUALIFYING EVENT.**

#### **Medicare extension for spouse and dependent children**

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the spouse and dependent children will end three years from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be 18 months).

### **Children born to or placed for adoption with the covered employee during COBRA period**

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

### **Alternate recipients under QMCSOs**

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Program Administrator during the covered employee's period of employment with the employer is entitled to the same rights under COBRA as a dependent child of the covered employee, regardless of whether that child would otherwise be considered a dependent.

### **Keep Your Plan Informed of Address Changes**

**In order to protect your family's rights, you should keep the Program Administrator informed of any changes in the addresses of family members.** You should also keep a copy, for your records, of any notices you send to the Plan Administrator. Contact GaBreeze 1-877-342-7339 to report a change.

## **TERMINATION OF INSURANCE REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993**

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

### **A. Continuation of Vision Insurance During Leave**

Your vision insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your vision insurance during such leave must be paid by you.

## **B. Reinstatement of Canceled Insurance Following Leave**

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled vision insurance will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

## **RETIREE AND SURVIVING SPOUSE/DEPENDENT CONTINUATION OF COVERAGE**

Employees and their dependents that are eligible to participate and were enrolled in the vision plan at the time of retirement may elect to continue their coverage through **COBRA**.

## **VISION CONVERSION**

There is no conversion privilege under the Vision Plan.

## **DENIALS & APPEALS**

### **Denials**

If a claim is partially paid, you will receive a written notice explaining how the claim was processed and giving notice of your appeal rights as to the unpaid portion. If a claim is denied in whole, a written Notice of Benefit Determination will be sent to you. This notice will include:

- The address and timeframe for submitting an appeal.
- A statement that an appeal must be submitted in writing, and any other
- Information that should be included with the appeal request.
- A statement that you have a right to submit written comments, documents, records and other information relating to the claim.
- A statement that you will be provided, at no charge and upon request, reasonable access to and copies of all documents, records and other information relevant to the claim.
- A statement that you and the plan may have other voluntary dispute resolution options, such as mediation, and information about how to obtain information about such options.
- A statement that you may have a right to bring a civil action under section 502(a) of ERISA following a denial of an appeal.

- A statement that you will be provided, at no charge and upon request, a copy of any specific internal rules, guidelines or protocols that were relied upon in denying the claim.
- A statement that you will be provided, upon request and at no additional charge, an explanation of any scientific or clinical basis for denying the claim.

## **Appeals**

You, or your duly authorized representative, may appeal the denial. Appeals should be submitted to: OptumHealth Vision Appeals, Claims Department, 6220 Old Dobbin Lane, Liberty 6, Suite 200, Columbia, MD 21045. Appeals must be in writing and received by OptumHealth Vision within 180 days after your receipt of the Notice of Benefit Determination. If this Notice is not received by you within 30 days of submission of the original claim, you may submit an appeal within 180 days after this 30-day period has expired. Appeals will be decided within 60 days after receipt by OptumHealth Vision. If an appeal is denied, a written Notice of Benefit Appeal Determination will be sent to you.

This notice will include similar information as the Notice described in the Denials section above.

Telephone inquiries concerning appeals should be made to: OptumHealth Vision Claims, Appeals Department, 1-800-638-3120.

## **Legal Action**

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against OptumHealth Vision in federal court until you have completed the Appeal process.

## **DEFINITIONS**

### **Active Service**

You will be considered in Active Service if:

- you are able to do the normal tasks of your job on a full-time basis for a full work day on the day your insurance is to begin, and
- you are able to do such tasks at one of your employer's normal places of business or at a location to which you must travel to do your job; and
- you are not absent from work because of sickness, disability or temporary lay-off.

## DEPENDENTS

Dependents are:

- Any eligible Spouse, Dependent child, or Totally Disabled Child.
- A **natural child** for which the natural guardian has not relinquished rights through a judicial decree. Eligibility begins at birth and ends at the end of the month in which the child reaches age twenty-six (26).
- An **adopted child**. Eligibility begins on the date of legal placement for adoption and ends at the end of the month in which the child reaches age twenty-six (26).
- A **stepchild**. Eligibility begins on the date of marriage to the natural parent. Eligibility ends at the end of the month in which the child reaches age twenty-six (26), or at the end of the month in which the stepchild loses his or her status as stepchild of the enrolled employee, whichever is earlier.
- **Guardianship**. A child for whom the enrolled employee is the legal guardian. Eligibility begins on the date the legal guardianship is established. Eligibility ends at the end of the month in which the child reaches age twenty-six (26), or at the end of the month in which the legal guardianship terminates, whichever is earlier. Certification documentation requirements are at the discretion of the Administrator. However, a judicial decree from a court of competent jurisdiction is required unless the Administrator concludes that documentation is satisfactory to establish legal guardianship.
- **Totally Disabled Child**. A natural child, legally adopted or stepchild age twenty-six (26) or older, if the child was physically or mentally disabled before age twenty-six (26), continues to be physically or mentally disabled, lives with the enrolled employee or is institutionalized, and depends primarily on the enrolled employee for support and maintenance.

## Employee

The term Employee means someone who:

- completes the waiting period (described in the Date of Eligibility section); and
- is a full-time employee of the State of Georgia, or a State Agency. "Full-time" means someone who works at least 30 hours a week, on a continuous basis, and whose employment is expected to last at least nine (9) months. The following are certain categories of employees specifically excluded: student, seasonal, part-time, short-term and sheltered workshop; or
- is a public school teacher who is employed in a professionally certificated capacity working 17.5 hours or more per week.
- is an employee of a local school system who holds a noncertificated position and who is eligible to participate in the Teachers Retirement System or its equivalent and working at least 20 hours a week (or 60% of the time necessary to carry out the duties of the position if that's more than 20 hours); or

- is an employee who is eligible to participate in the Public School Employee Retirement System as defined by 20 of Section 47-4-2 of the Official Code of Georgia, Annotated and who works at least 15 hours a week (or 60% of the time necessary to carry out the duties of the position); or
- is an employee of a county or regional library and working at least 17.5 hours or more; or
- is deemed eligible by Federal or Georgia law.

**Employer**

The terms Employer and Participating Employer mean any Employer who has signed a Request for Participation in the OptumHealth Vision Plan and whose request has been approved by the Insurance Company. These terms also include Affiliated Employers.

Affiliated Employers are those employers specified as affiliated employers in the participating Employer's Request for Participation in accordance with its terms.

**Medicaid**

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

**Medicare**

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

**Plan Year (Contract Year)**

The period beginning January 1 and ending on December 31.

**Provider**

The term Provider means a person practicing optometric care within the scope of his/her license. It will also include a physician operating within the scope of his/her license when he/she performs any of the Vision Services described in the policy.

**OptumHealth Vision**

OptumHealth Vision is a wholly-owned subsidiary of the UnitedHealth Group that contracts with Participating Providers for the provision of vision care. OptumHealth Vision also provides management and information services to Policyholders and Participating Vision Facilities.