# PRIESTS OF THE ARCHDIOCESE OF DUBUQUE
# DUBUQUE IA

**Vision Benefit Summary Plan Description**
**7670-04-411619**

**Revised 01-01-2022**

**BENEFITS ADMINISTERED BY**

UMR℠

A UnitedHealthcare Company

# Table of Contents

# PRIESTS OF THE ARCHDIOCESE OF DUBUQUE

# GROUP VISION BENEFIT PLAN

# SUMMARY PLAN DESCRIPTION

## INTRODUCTION

The purpose of this document is to provide You, if any, with summary information in English on benefits available under this Plan, as well as with information on a Covered Person's rights and obligations under the PRIESTS OF THE ARCHDIOCESE OF DUBUQUE Vision Benefits Plan (the "Plan"). You are a valued Ordained Priest of PRIESTS OF THE ARCHDIOCESE OF DUBUQUE, and Your employer is pleased to sponsor this Plan to provide benefits that can help meet Your vision care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions or if You have difficulty translating this document.

PRIESTS OF THE ARCHDIOCESE OF DUBUQUE is named the Plan Administrator for this group vision Plan. The Plan Administrator has retained the services of an independent Third Party Administrator, UMR, Inc. (hereinafter "UMR") to process claims and handle other duties for this self-funded Plan. UMR, as Third Party Administrator, does not assume liability for benefits payable under this Plan, since it is solely a claims-paying agent for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Ordained Priests help cover some of the costs of covered benefits through contributions, Deductibles, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits.

Some of the terms used in this document begin with capital letters, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this group vision Plan.

Each individual covered under this Plan will be receiving an identification card that he or she may present to providers whenever he or she receives services. On the back of this card are phone numbers to call in case of questions or problems.

This document summarizes the benefits and limitations of the Plan and will serve as the SPD and Plan document. Therefore it will be referred to as both the Summary Plan Description ("SPD") and Plan document.

This document becomes effective on January 1, 2014.

## PLAN INFORMATION

| | |
|---|---|
| **Plan Name** | PRIESTS OF THE ARCHDIOCESE OF DUBUQUE GROUP BENEFIT PLAN |
| **Name And Address Of Employer** | PRIESTS OF THE ARCHDIOCESE OF DUBUQUE<br>1229 MOUNT LORETTA AVE<br>DUBUQUE IA 52003 |
| **Name, Address And Phone Number Of Plan Administrator** | PRIESTS OF THE ARCHDIOCESE OF DUBUQUE<br>1229 MOUNT LORETTA AVE<br>DUBUQUE IA 52003<br>563-556-2580 |
| **Named Fiduciary** | PRIESTS OF THE ARCHDIOCESE OF DUBUQUE |
| **Employer Identification Number Assigned By The IRS** | 42-1096954 |
| **Type Of Benefit Plan Provided** | Self-funded Health & Welfare Plan providing group vision benefits |
| **Type Of Administration** | The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for vision claims. |
| **Name And Address Of Agent For Service Of Legal Process** | PRIESTS OF THE ARCHDIOCESE OF DUBUQUE<br>1229 MOUNT LORETTA AVE<br>DUBUQUE IA 52003<br><br>Services of legal process may also be made upon the Plan Administrator. |
| **Funding Of The Plan** | Ordained Priest Contributions<br><br>Benefits are provided by a benefit Plan maintained on a self-insured basis by Your employer. |
| **Benefit Plan Year** | Benefits begin on January 1 and end on the following December 31. For new Ordained Priests, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year. |
| **Plan's Fiscal Year** | January 1 through December 31 |
| **Compliance** | It is intended that this Plan comply with all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict. |

**Discretionary Authority**

The Plan Administrator will perform its duties as the Plan Administrator and in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this Summary Plan Description (SPD) and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrator for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrator will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or Third Party Administrator will be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrator at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrator makes, in their sole discretion, and further means that the Covered Person consents to the limited standard and scope of review afforded under law.

## BENEFIT CLASS DESCRIPTION

The Covered Person's benefit class is determined by the designations shown below:

| Class | Class Description | Benefit Plan |
|---|---|---|
| A01 | ALL ACTIVE ORDAINED PRIESTS | 001 |
| A02 | ALL RETIRED ORDAINED PRIESTS | 001 |

## LOCATION DESCRIPTION

| Location | Description | Billing Division | Reporting Sub |
|---|---|---|---|
| 001 | PRIESTS OF THE ARCHDIOCESE OF DUBUQUE<br>1229 MOUNT LORETTA AVE<br>DUBUQUE IA 52003 | 001 | 0001 |

## SCHEDULE OF BENEFITS

### Vision Plan
### Benefit Plan 001

All vision benefits shown on this Schedule of Benefits are subject to annual maximums and are subject to all provisions of this Plan, including Medical Necessity and any other benefit determination based on an evaluation of medical facts and covered benefits.

| SUMMARY OF BENEFITS | |
|---|---|
| **Vision Care Benefits:** | |
| **Eye Exam:** | |
| • Maximum Exams Every Calendar Year | 1 Exam |
| • Copay Per Exam | $10 |
| • Paid By Plan After Copay | 100% |
| **Eye Refraction:** | |
| Included In Eye Exam Maximum | |
| • Maximum Exams Every Calendar Year | 1 Exam |
| • Paid By Plan | 100% |
| **Lenses – All:** | |
| • Maximum Benefit Every Calendar Year | 2 Lens |
| **Lenses – Single:** | |
| • Copay | $25 |
| • Paid By Plan After Copay | 100% |
| **Lenses – Bifocal:** | |
| • Copay | $25 |
| • Paid By Plan After Copay | 100% |
| **Lenses – Trifocal:** | |
| • Copay | $25 |
| • Paid By Plan After Copay | 100% |
| **Lenses – Bifocal Lenticular:** | |
| • Copay | $25 |
| • Paid By Plan After Copay | 100% |
| **Lenses – Progressive/Trifocal Lenticular:** | |
| • Copay | $120 |
| • Paid By Plan After Copay | 100% |
| **Lens Options- Anti Reflective Coating** | |
| • Copay | $68 |
| • Paid By Plan After Copay | 100% |

| SUMMARY OF BENEFITS | |
|---|---|
| **Frames:** | |
| • Maximum Benefit Every 24 Months | 1 Frame |
| • Maximum Benefit Per Calendar Year | $130 |
| • Paid By Plan After Copay | 100% |
| **Elective Contacts:** | |
| • Maximum Benefit Per Calendar Year | $130 |
| • Paid By Plan After Copay | 100% |

# OUT-OF-POCKET EXPENSES

## PLAN PARTICIPATION

Plan Participation means the Covered Person and the Plan each pay a percentage of the Covered Expenses. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

## ADDITIONAL OUT-OF-POCKET EXPENSES

In addition to the Plan Participation percentage, the Covered Person is also responsible for the following costs:

- Any remaining charges due to the provider after the Plan's benefits are determined.
- Full charges for services that are not covered benefits under this Plan.
- Legal fees and interest charged by a provider.

## INDIVIDUAL CALENDAR YEAR MAXIMUM BENEFIT

All Covered Expenses will count toward the Covered Person's individual vision Calendar Year Maximum Benefit that is shown on the Schedule of Benefits, as applicable.

For Covered Persons who were terminated from the Plan and are reinstated within 30 days following a lapse in coverage (for example, a Covered Person ends employment and later is re-hired and re-enrolls in this Plan), the Annual Maximum Benefit will not start over. The Annual Maximum Benefit will continue to accumulate from the level satisfied at the time of the Covered Person's termination.

## NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles or required Plan Participation) under the terms of this Plan. The requirement that You pay the applicable out-of-pocket expenses cannot be waived by a provider under any "fee forgiveness", "not out-of-pocket" or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

# ELIGIBILITY AND ENROLLMENT

## ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. The Plan may request documentation from You in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Ordained Priests.

## ELIGIBILITY REQUIREMENTS

An **eligible Ordained Priest** is a person who is classified by the employer on both payroll and personnel records as an Ordained Priest who regularly works full-time, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Temporary or leased Ordained Priests.
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Ordained Priest may retain eligibility for coverage under this Plan if the Ordained Priest is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. If an Ordained Priest loses full time employment due to the COVID-19 disaster declaration, their eligibility requirements will continue to be considered as met from March 13, 2020 through December 31, 2020.The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency, or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

An eligible Ordained Priest who is covered under this Plan and who retires under the employer's formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution. See the Coordination of Benefits section for more information on how this Plan coordinates with Medicare coverage. Retirees may continue coverage under this Plan until after age 65.

Note: Eligible Ordained Priests who decline to enroll in this Plan must state so in writing.

## EFFECTIVE DATE OF ORDAINED PRIEST'S COVERAGE

Your coverage will begin on the later of the following dates:

- If You apply within 30 days of hire, Your coverage will become effective the first day of the month the Ordained Priest becomes an ordained priest; or

- If You apply after 30 days of hire, You will be considered a Late Enrollee. Coverage for a Late Enrollee will become effective the date You apply for coverage.

# TERMINATION

## ORDAINED PRIEST'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You or Your employer tells the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment; or
- The last day of the month in which You are no longer a member of a covered class, as determined by the employer except if You are temporarily absent from work due to active military duty. Refer to USERRA under the USERRA section.
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

## RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- It has only a prospective effect; or
- It is attributable to non-payment of premiums or contributions; or
- It is initiated by You or Your personal representative.

## REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment and You qualify for eligibility under this Plan again at a later date, You are eligible for coverage on the date You again meet all the eligibility requirements of this Plan. Refer to the information on Family and Medical Leave Act or Uniformed Services Employment and Reemployment Act for possible exceptions, or contact Your Human Resources or Personnel office.

## UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

### INTRODUCTION

Ordained Priests on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated Ordained Priests on leaves of absence or furloughs. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Ordained Priests on military leave. Reinstatement following a military leave of absence cannot be subject to Waiting Periods.

### COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- A period beginning on the day that the service leave begins and ending on the day after the Ordained Priest fails to return to or reapply for employment within the time allowed by USERRA.

### USERRA NOTICE AND ELECTION

An Ordained Priest or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Ordained Priest intends to leave the employment position to perform service in the uniformed services. An Ordained Priest should provide notice as far in advance as is reasonable under the circumstances. The Ordained Priest is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed services, Ordained Priests will be given the opportunity to elect USERRA continuation.

### PAYMENT

If the military leave orders are for a period of 30 days or less, the Ordained Priest is not required to pay more than the amount he or she would have paid as an active Ordained Priest. For periods of 31 days or longer, if an Ordained Priest elects to continue vision coverage pursuant to USERRA, such Ordained Priest and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

### EXTENDED COVERAGE RUNS CONCURRENTLY

Election of USERRA extension by an Ordained Priest on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Ordained Priest will generally be extended. Coverage under both laws will run concurrently.

## VISION CARE BENEFITS COVERED EXPENSES

The Plan will pay for covered services for vision care Incurred by a Covered Person, subject to any required Deductible, Co-pay, if applicable, participation amount, maximums, and limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge, the maximum fee schedule, or the Negotiated Rate.

### COVERED BENEFITS

- Eye exam.
- Refraction.
- Lenses.
  - Single.
  - Bifocal.
  - Trifocal.
  - Bifocal Lenticular.
  - Progressive/Trifocal Lenticular.
- Frames.
- Elective contacts.

### EXCLUSIONS

Benefits will NOT be provided for any of the following:

- Contact lens fitting.
- Safety lenses and frames.
- Eye surgeries used to improve or correct eyesight for refractive disorders, including LASIK surgery, radial keratotomy, refractive keratoplasty, or similar surgery.
- Sunglasses or subnormal vision aids.
- The fitting and/or dispensing of non-prescription glasses or vision devices whether or not prescribed by a physician or Optometrist.
- Vision therapy services (including orthoptics) or supplies.
- Correction of visual acuity or refractive errors.
- Aniseikonia.

## COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has vision coverage under more than one Plan, as defined below. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules below determine which plan will pay first (i.e., which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. If the covered benefit under this Plan is less than or equal to the Primary Plan's payment, then no payment is made by this Plan.

The Plan will coordinate benefits with the following types of medical or vision plans:

- Group vision plans, whether insured or self-insured.
- Group health plans, whether insured or self-insured.
- Specific disease policies.
- Foreign policies.
- Medical coverage related to vision care under group or individual automobile policies. See order of benefit determination rules (below).
- Medicare or other governmental benefits as permitted by law, not including Medicaid. See below.

This Plan does not, however, coordinate benefits with individual health or vision plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

### ORDER BENEFIT OF DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply.

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments related to vision care are available under motor vehicle insurance (including no-fault policies), this Plan will always be considered secondary regardless of the individual's election under Personal Injury Protection (PIP) coverage with the auto carrier.

- Active or Inactive Ordained Priest: If an individual is covered under one plan as an active Ordained Priest, and is also covered under another plan as a retired or laid off Ordained Priest, the plan that covers the person as an active Ordained Priest will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation Coverage Under State Law: If a person has elected continuation of coverage under state law, and also has coverage under another plan, the continuation coverage is secondary. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies.

- Longer or Shorter Length of Coverage: The plan that has covered the person as an Ordained Priest, member, subscriber, or retiree the longest is primary.

- If an active Ordained Priest is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Ordained Priest, member or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

**TRICARE**

If an eligible Ordained Priest is on active military duty, TRICARE is the only coverage available to that Ordained Priest. Benefits are not coordinated with the Ordained Priest's vision insurance plan.

In all instances where an eligible Ordained Priest is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

**RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION**

Certain facts about vision care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. Each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

**REIMBURSEMENT TO THIRD PARTY ORGANIZATION**

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

**RIGHT OF RECOVERY**

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

## GENERAL EXCLUSIONS

The Plan does not pay for expenses Incurred for the following, even if deemed to be Medically Necessary, unless otherwise stated below.

1. **Acts of War**: Illness or Injury caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

2. **Appointments Missed**: Appointments the Covered Person did not attend.

3. **Before Effective Date and After Termination**: Services, supplies or expenses Incurred before coverage begins under this Plan, or after coverage ends are not covered.

4. **Cosmetic**: Services or treatment for cosmetic purposes as determined by the Plan.

5. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The Plan will enforce this exclusion based upon reasonable information showing that the criminal activity took place.

6. **Excess Charges:** Charges or the portion thereof that are in excess of the Usual and Customary charge, the Negotiated Rate, or the fee schedule.

7. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment that the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatments.

8. **Interest and Legal Fees**.

9. **Medications**, whether prescription or over-the-counter, other than those administered while in the Ophthalmologist's or Optometrist's office as part of treatment.

10. **Military:** A military-related Illness of or Injury to a Covered Person on active military duty, unless payment is legally required.

11. **Myofunctional Therapy**.

12. **Professionally Recognized Standards**: Procedures that are not necessary and do not meet professionally recognized standards of care.

13. **Replacement** of lost, missing or stolen appliances regardless of any other provision of this Plan.

14. **Services At No Charge or Cost:** Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense code, or as required by law.

15. **Services Not Furnished by an Optometrist or Ophthalmologist.**

16. **Services Provided By a Close Relative.** See the Glossary of Terms section of this SPD for a definition of "Close Relative."

17. **Worker's Compensation**: An Illness or Injury arising out of or in the course of any employment for wage or profit, including self-employment, for which the Covered Person is entitled to benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, policy or contract, where required by state law. This exclusion does not apply to any Ordained Priests while working for the Archdiocese of Dubuque

**Benefits not specifically included in the Covered Benefits section of this document are considered excluded**.

# CLAIMS AND APPEAL PROCEDURES

## REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

## TYPE OF CLAIMS AND DEFINITIONS

**Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

## PERSONAL REPRESENTATIVE

**Personal Representative** means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claims Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

## PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below. The address for submitting claims is on the back of the group vision identification card.

A Covered Person who receives services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Person for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if the paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, Social Security number, address, and relationship to Ordained Priest
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient's account number (if applicable)
- Total billed charges
- Provider's billing name, address, and telephone number

- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto accident, or another accident (if applicable)
- Assignment of benefits (if applicable)

**TIMELY FILING**

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all of the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

**HOW VISION BENEFITS ARE CALCULATED**

When UMR receives a claim for a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group vision Plan. If the service is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If the service is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to an established fee schedule, according to a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

**Fee Schedule:** Providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying.

**Negotiated Rate**: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service. The Negotiated Rate is what the Plan will pay to the provider, minus any Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying.

**NOTIFICATION OF BENEFIT DETERMINATION**

Each time a claim is submitted by a Covered Person or a provider on behalf of a Covered Person, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group vision identification card. The provider will receive a similar form on each claim that is submitted.

**TIMELINES FOR INITIAL BENEFIT DETERMINATION**

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

## CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person's loss of eligibility for coverage under the vision Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group vision plan.
- Termination of the group vision plan.
- The Ordained Priest or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Ordained Priest is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Procedures are considered Experimental, Investigational, or Unproven.
- Other reasons as stated elsewhere in this SPD.

## ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

**Adverse Benefit Determination** means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

## APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his/her Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

**First Level of Appeal**: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume that the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or his or her Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or a victim of an act of domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision, and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a vision judgment, the Plan will consult with a vision care professional with training and experience in the relevant vision field. This vision care professional may not have been involved in the original denial decision, and may not be supervised by the vision care professional who was involved. If the Plan has consulted with vision or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

**Second Level of Appeal**: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 60 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume that the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or a victim of an act of domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.

- If the benefit denial was based in whole or in part, on a vision judgment, the Plan will consult with a vision care professional with training and experience in the relevant vision field. This vision care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the vision care professional who was involved. If the Plan has consulted with vision or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his or her rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal, including applicable rules, a Covered Person's right to representation (i.e., to appoint a Personal Representative) or other details, please contact the Plan.

**Appeals should be sent within the prescribed time period as stated above to the following address(es):**

UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

**TIME PERIODS FOR MAKING DECISION ON APPEALS**

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

Post-Service claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.

**RIGHT TO EXTERNAL REVIEW**

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the adverse benefit determination is based on:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven Services; or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fails to respond to Your appeal within the time lines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR or Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR
EXTERNAL REVIEW
APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Ordained Priest's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a qualified expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical or vision records;
- All other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your physician has already submitted to UMR or Your employer.

If there is any information or evidence that was not previously provided and that You or Your physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

**RIGHT TO REQUEST OVERPAYMENTS**

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to a Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against the Covered Person if the Plan has paid them or any other party on their behalf.

# FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek vision treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

## OTHER FEDERAL PROVISIONS

### FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Ordained Priest is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Ordained Priest has written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the FMLA and any amendment; or
- The leave period required by applicable state law.

An Ordained Priest may choose not to retain group health coverage during an FMLA leave. When the Ordained Priest returns to work following the FMLA leave, the Ordained Priest's coverage will usually be restored to the level the Ordained Priest would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

**This group vision Plan also complies with the provisions of the:**

- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.

## HIPAA ADMINISTRATIVE SIMPLIFICATION
## MEDICAL PRIVACY AND SECURITY PROVISION

### USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor will use and/or disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan.

This Plan agrees that it will disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will use and disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Ordained Priest benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not Use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about a Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that a Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of a Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs a Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Ordained Priests, classes of Ordained Priests or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan administrative functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Director of Human Resources

This list includes every Ordained Priest, class of Ordained Priests or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Ordained Priests or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Ordained Priests or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to the Covered Person.

**DEFINITIONS**

**Administrative Simplification** is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

**Business Associate (BA) in relationship to a Covered Entity (CE)** means a person to whom a CE Discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

**Covered Entity (CE)** is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

**Designated Record Set** means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical or vision records, billing records, enrollment records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

**Disclosure** is the release or divulgence of information by an entity to persons or organizations outside that entity.

**Electronic Protected Health Information (Electronic PHI)** is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

**Health Care Operations** are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical (or vision) review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

**Individually Identifiable Health Information** is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present or future Payment for the provision of health care; and
- Identifies the Covered Person or there is reasonable basis to believe the information can be used to identify the Covered Person.

**Payment** means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

**Plan Sponsor** means Your employer.

**Plan Administrative Functions** means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

**Privacy Official** is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

**Protected Health Information (PHI)** is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic or oral form. PHI includes Electronic PHI.

**Treatment** is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

**Use** means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

## PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

### COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

### DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post tax contributions paid by Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

### NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between any Covered Person and the employer.

## GLOSSARY OF TERMS

**Accidental Vision Injury / Injury** means damage to the eye due directly to a blow.

**Adverse Benefit Determination** means a denial, reduction, or termination of a benefit or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

**Close Relative** means a member of the immediate family. Immediate family includes the Ordained Priest, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, and half siblings.

**Covered Expenses** means any expense, or portion thereof, that is Incurred as a result of receiving an eligible benefit under this Plan.

**Covered Person** means an Ordained Priest or Retiree who is enrolled under this Plan.

**Deductible** means the amount of Covered Expenses that must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the individual and family Deductible (if any) and the vision care benefits to which it applies.

**Effective Date** means the first day of coverage as defined in this SPD. The Covered Person's Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

**Emergency Vision Care** means care of a vision condition that is required unexpectedly and immediately because of an Injury or Illness.

**Enrollment Date** means:

- For anyone who applies for coverage when first eligible, the date that coverage begins.
- For anyone who enrolls for Late Enrollees, the first day coverage begins.

**Experimental, Investigational or Unproven** means any drug, service, supply, care or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);

- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;

- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;

- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

**FMLA** means the Family and Medical Leave Act of 1993, as amended.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

**Illness** means a bodily disorder, disease, or physical sickness affecting the eyes.

**Incurred** means the date on which a service or treatment is given, a supply is received or a facility is used, without regard to when the service, treatment, supply or facility is billed, charged or paid.

**Independent Contractor** means someone who signs an agreement with the employer as an Independent Contractor or an entity or individual who performs services to or on behalf of the employer who is not an Ordained Priest or an officer of the employer and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

**Late Enrollee** means a person who enrolls under this Plan other than on the earliest date on which coverage can become effective under the terms of this Plan.

**Legal Guardianship / Legal Guardian** means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

**Maximum Benefit** means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

**Medically Necessary/Medical Necessity** means treatment, services, supplies, medicines, or facilities necessary and appropriate for the diagnosis, care, or treatment of an Illness or Injury that meet all of the following criteria as determined by the Plan:

- The health intervention is for the purpose of treating a vision condition; and
- It is the most appropriate supply or level of service, considering potential benefits and harm to the patient; and
- It is known to be effective in improving vision outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, and finally by expert opinion; and
- It is cost-effective for a specific condition, compared to alternate interventions, including the option of no intervention. The term "cost-effective" does not necessarily mean for the lowest price; and
- It is not primarily for the convenience or preference of the Covered Person, for the Covered Person's family, or for any provider; and
- It is not Experimental, Investigational, cosmetic or custodial in nature; and

- It is currently, or at the time the charges were Incurred, recognized as acceptable medical practice by the Plan.

The fact that an Optometrist and/or Ophthalmologist has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or the fact that such service, treatment plan, supply, medicine, Equipment or facility is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

**Negotiated Rate** means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

**Optometrist** means a licensed, Qualified provider trained to diagnose, manage, and treat a multitude of visual and ocular health-related concerns, including, but not limited to, fitting and prescribing spectacles and contact lenses, treating minor ocular Injuries, diagnosing and treating diseases such as glaucoma and diagnosing others such as diabetic retinopathy. Optometrists do not perform surgery.

**Ophthalmologist** means a physician who specializes in the anatomy, functions, pathology, and treatment of the eye. Ophthalmologists are generally classified as surgeons.

**Ordained Priest** – see the Eligibility and Enrollment section of this SPD.

**Placed For Adoption / Placement For Adoption** means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

**Plan** means the PRIESTS OF THE ARCHDIOCESE OF DUBUQUE Group Vision Benefit Plan.

**Plan Participation** means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

**Plan Sponsor** means an employer who sponsors a group vision plan.

**Qualified** means licensed, registered and/or certified in accordance with the applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

**Qualified Provider** means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

**Retired Ordained Priest (Retiree)** means a person who was employed full time by the employer who is no longer regularly at work and who is now retired under the employer's formal retirement program.

**Third Party Administrator (TPA)** means a service provider hired by the Plan to process vision claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

**You / Your** means the Ordained Priest.