

**2020**

**Effective Plan Year**

**UPMC Health Benefits Inc.**

**U.S. Steel Tower**

**600 Grant Street**

**Pittsburgh, PA 15219**

**Pediatric Vision\***

**Certificate of Insurance**

\*The vision coverage described in this document is deemed an Essential Health Benefit (EHB) for Members up to the age of 19 and applies only to those Members who meet this criteria.

**UPMC Vision Care**

## Welcome and General Information for Members

This is your Certificate of Insurance ("Certificate"). If this Certificate has been purchased on behalf of a child, references to "you" or "your" should be considered to reference the child. Your Certificate establishes the terms of coverage only for this vision plan for those Members up to the age of 19. It sets forth what services are covered and what services are not covered. It explains the procedures that you must follow to ensure that the vision services you receive will be covered under your benefit plan. It also describes how you submit a claim, file a Complaint, and other information that you may need to know to access your vision benefits. The Certificate acts as a contract between you and the Plan, \* setting forth your obligations as a Member and our obligations as your vision benefits carrier. It is important to use this Certificate along with your Pediatric Vision Schedule of Benefits. Your Pediatric Vision Schedule of Benefits is the document that outlines your coverage amount and Benefit Limits. Anything contained herein to the contrary notwithstanding, UPMC Vision Care shall have the right, for the purpose of complying with the provisions of any law or any lawful order of a regulatory authority, to amend the Policy or any attachment hereto or to increase, reduce, or eliminate any of the benefits provided for in the Policy for any one or more eligible Members enrolled under the Policy, and each party hereby agrees to any amendment of the Policy which is necessary in order to accomplish such purpose

**This Preferred Provider Organization benefit plan may not cover all of your vision expenses. Read this Certificate carefully to determine which vision services are covered.**

### Health Care Concierge team

To help you get accurate answers to questions and up-to-date information about your vision program, please log in to MyHealth OnLine via [www.upmchealthplan.com](http://www.upmchealthplan.com), call 1-844-252-0687, or write to UPMC Vision Care, U.S. Steel Tower, 600 Grant Street, Pittsburgh, PA 15219. You can:

- Learn about UPMC Vision Care.
- Find network vision providers.
- Verify eligibility.
- Request an Out-of-Network Reimbursement Form.
- Speak with our Health Care Concierge team via phone or online chat.
- Ask any questions about your vision care benefits.
- Initiate a Complaint of a benefit denial.

Our Health Care Concierge team is available Monday through Friday from 7 a.m. to 7 p.m. and Saturday from 8 a.m. to 3 p.m. at 1-844-252-0687. Members who use a TTY (teletypewriter) may access TTY services by calling 711 .

### Helpful phone numbers:

- Member Health Care Concierge – 1-844-252-0687
- Provider Line – 1-877-262-7870
- TTY Services – 711
- Provider Fraud and Abuse – 1-866-FRAUD01 (1-866-372-8301)
- UPMC Fax – 1-888-830-5560

\*UPMC Vision Care is a product of UPMC Health Benefits Inc. and is administered by National Vision Administrators (NVA). Please note that throughout this document, we use the terms "UPMC Vision Care," "UPMC Health Plan" and "the Plan" to refer to UPMC Health Benefits Inc. as well as to UPMC Health Plan Inc.

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## Terms and Definitions to Help You Understand Your Coverage

The following are some important, frequently used terms and definitions that the Plan uses in this Certificate and when administering your benefits.

**Benefit Limit** – The maximum amount that the Plan will pay for a Covered Service. Some Benefit Limits are discussed in this Certificate, but generally Benefit Limits are set forth in your Schedule of Benefits.

**Benefit Period** – The period (for which you are eligible for coverage during your contract year during which charges for Covered Services must be incurred in order to be eligible for payment by the Plan. A charge is considered incurred on the date you receive the service or supply.

**Complaint** – A dispute or objection by a Member regarding a Participating Vision Provider or the coverage (including contract exclusions and noncovered benefits), operations, or management policies of this vision plan, which has not been resolved by the Plan and has been filed with the Plan. Instructions on how to file a Complaint are set forth in the Resolving Disputes with the Plan section of this Certificate.

**Copayment** – The specified dollar amount that you pay at the time of service, for certain Covered Benefits. Copayments do not apply toward your coinsurance or deductible. You are expected to pay Copayments at the time of service. Refer to the Pediatric Vision Schedule of Benefits to determine Copayment amounts.

**Covered Benefit or Covered Service** – A service or supply that meets the requirements set forth in this Certificate.

**Daily Wear Contact Lenses** – Contact lenses that are approved and intended for wear during a single awake period of time, not to exceed the number of hours recommended by an eye care professional. Each day they are to be removed from the eye, cleaned, and sterilized. They are not intended for or approved for sleep.

**Experimental/Investigational** – Any treatment, procedure, equipment, drug, device, or supply which is not accepted standard vision practice by the general vision community or does not have federal or government agency approval.

**Extended Wear (Planned Replacement/Frequent Replacement) Contact Lenses** – Contact lenses that may be utilized for a specified period of time, i.e., daily, one week, two weeks, etc., at which time they are discarded. In most cases they are removed, cleaned, and sterilized following wear. In some cases they may be worn while sleeping, if approved by an eye care professional. Wearing schedules and duration of use must be as prescribed.

**Maximum Allowable Charge** – The maximum amount the Plan will allow for a Covered Service.

**Medical Necessity or Medically Necessary** – Health care services covered under your benefit plan that are determined by UPMC Health Plan or UPMC Vision Care to be:

- Commonly recognized throughout the provider's specialty as appropriate for the diagnosis and/or treatment of the Member's condition, illness, disease, or injury.
- Provided in accordance with standards of good medical practice and consistent with scientifically based guidelines of medical, research, or health care coverage organizations or governmental agencies that are accepted by UPMC Health Plan.
- Reasonably expected to improve an individual's condition or level of functioning and in conformity at the time of treatment with medical management criteria/guidelines adopted by UPMC Health Plan or

its designee.

- Provided not only as a convenience or comfort measure or to improve physical appearance.
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service.

UPMC Health Plan/UPMC Vision Care reserves the right to determine whether a visioncare service meets these criteria. Approval for coverage based upon Medical Necessity shall be made by UPMC Health Plan/UPMC Vision Care, at its discretion, with input from the treating provider. Note that the fact that a provider orders, prescribes, recommends, or approves a health care service does not mean that the service is Medically Necessary or a Covered Benefit for purposes of coverage.

**Member** – An individual who is enrolled in and covered by this Certificate.

**Nonparticipating Vision Laboratory** – An optical laboratory that creates, promotes, sells, provides, advertises or administers vision care supplies who is not contracted with National Vision Administrators.

**Nonparticipating Vision Provider** – A vision provider who is not a contracted provider with the Plan.

**National Vision Administrators, L.L.C. (NVA)<sup>®</sup>** – A third party vision administrator that provides benefit programs and a provider network for UPMC Vision Care Members.

**Participating Vision Laboratory** – An optical laboratory who has entered into an agreement with the Plan to render Covered Services to UPMC Vision Care Members through an arrangement with National Vision Administrators.

**Participating Vision Provider** – A vision provider who has entered into an agreement with the Plan to render Covered Services to UPMC Vision Care Members. A Participating Vision Provider may also include participating providers who use an out-of-network vision laboratory.

**Pediatric Vision Schedule of Benefits** – List of Covered Services, Copayments, and limits.

**Prior Authorization** – A formal process requiring a provider to obtain approval to provide particular services or procedures before they are done. This is usually required for nonemergency services that are expensive or likely to be abused or overused. A managed care organization will identify those services and procedures that require prior authorization, without which the provider may not be compensated.

**Proof of Loss** – Documentation to support a claim.

**Service Area** – The Plan's primary Service Area, which consists of the counties listed in the most current version of the UPMC Vision Care provider directory (or the online version). These are the counties in which UPMC Vision Care is licensed to do business and in which most of its Participating Vision Providers are located.

**Specialty Contact Lenses** – Lenses that require additional professional time in fitting and follow up care. These include rigid gas (O<sub>2</sub>) permeable lenses, toric (correct for astigmatism) lenses, and multi-focal lenses.

**Usual, Customary, and Reasonable (UCR)** – For the services authorized by UPMC Vision Care that are provided by a Nonparticipating Vision Provider, the UCR charge is the amount that UPMC Vision Care determines is reasonable for Covered Services pursuant to industry standards. The Nonparticipating Vision Provider may charge you the difference between the billed amount and the UCR amount.

## How the Vision Plan Works

### Choosing a vision provider

You are enrolled the UPMC Vision Care Preferred Provider Organization (PPO) vision plan administered by National Vision Administrators (NVA) which is your Pediatric Vision Essential Health Benefit (EHB). That means you have the ability to self-direct your care. You have two levels of benefits. You can use Participating Vision Providers, also called in-network providers, for all Covered Services, as well as Nonparticipating Vision Providers, which are also called out-of-network providers, for most Covered Services. If you obtain services from Participating Vision Providers, you will receive the highest level of benefit coverage. If you obtain services from Nonparticipating Vision Providers, you will receive a lower level of benefit coverage. Be sure to read this Certificate to determine whether a service will be covered if obtained from a Nonparticipating Vision Provider.

**Remember, if you use Nonparticipating Vision Providers, you may receive a lower level of benefit coverage and you may be billed by those Nonparticipating Vision Providers for the difference between the provider's charges and the allowed amount. This means that because the Plan does not contract with a Nonparticipating Vision Provider, the provider can bill you for any amount over and above what the Plan covers. Also, the Plan will not pay a Nonparticipating Vision Provider directly. This means you will have to pay the provider and submit an out-of-network claim form to obtain reimbursement of covered expenses.**

To find a Participating Vision Provider, log in to *MyHealth OnLine* at [www.upmchealthplan.com](http://www.upmchealthplan.com) or call our Health Care Concierge team at 1-844-252-0687. When you visit the vision provider's office, let your vision provider know that you are covered under UPMC Vision Care. If your vision provider has questions about your eligibility or benefits, instruct the office to call 1-877-262-7870 or visit [www.upmchealthplan.com/providers](http://www.upmchealthplan.com/providers). The vision provider may use demographic information, such as name and date of birth, to verify eligibility and submit claims.

### Out-of-network services

UPMC Vision Care encourages you to use Participating Vision Providers to maximize your benefit and minimize any out-of-network expenses. Participating Vision Providers can be located by visiting [www.upmchealthplan.com](http://www.upmchealthplan.com), clicking on Find Care at the top of the page, and then selecting Vision.

In the event you select to have services performed by a Nonparticipating Vision Provider, UPMC Vision Care will reimburse you for eligible services up to the benefit maximum. You may download an out-of-network claim form by logging in to *MyHealth OnLine* via [www.upmchealthplan.com](http://www.upmchealthplan.com) or call our Health Care Concierge team at 1-844-252-0687 to have a form sent to you.

### For care outside of Pennsylvania

To locate a participating out-of-area provider, visit our website at [www.upmchealthplan.com](http://www.upmchealthplan.com) or call the Health Care Concierge team at 1-844-252-0687 for assistance.

When using an out-of-area provider, identify yourself as a UPMC Vision Care Member, and they will verify eligibility and submit the claim on your behalf.

**Relationship with providers**

UPMC Vision Care recognizes the importance of maintaining the continuity of care rendered to you by your treating vision providers. Accordingly, to facilitate the management and quality of your overall treatment, the Plan may exchange information, including claims information, with your vision providers.

Remember, out-of-network providers do not have to comply with UPMC Vision Care policies and procedures. If you receive out-of-network services, you may be financially responsible for the difference between what UPMC Vision Care reimburses the Nonparticipating Vision Providers and the amount billed for the treatment and services.

## Benefits

UPMC Vision Care provides coverage for the following vision services in accordance with UPMC Health Plan policies and procedures. Refer to your Pediatric Vision Schedule of Benefits for Copayment amounts as well as any Benefit Limits related to Covered Services. You may obtain Covered Services from either Participating or Nonparticipating Vision Providers and receive varying levels of coverage, as discussed throughout this Certificate. Remember that a statement from your vision provider saying he or she believes you should have certain services does not mean that those services are Covered Services for purposes of coverage under your benefit plan.

### Services

The general descriptions below explain the services on your Pediatric Vision Schedule of Benefits. The descriptions are not all-inclusive – they include only the most common vision procedures in a class or service grouping. Specific vision procedures may not be covered depending on your Plan. Check your Pediatric Vision Schedule of Benefits to see what services are covered. Also, have your vision provider call UPMC Vision Care to verify coverage of specific vision procedures, or log in to MyHealth OnLine at [www.upmchealthplan.com](http://www.upmchealthplan.com) to check coverage. Services covered on your Pediatric Vision Schedule of Benefits are also subject to exclusions. Be sure to review the Schedule of Exclusions included in this Certificate and in your medical policy.

**Vision Examinations:** The comprehensive examination includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test), and dilation (if professionally indicated). Eligible Members are entitled to receive a vision examination every 12 months

- New patient
- Established patient

**Lenses:** Coverage is provided in full for standard polycarbonate eyeglass lenses.

- Single vision
- Bifocal
- Trifocal

Lens options may be at an additional cost to you or may not be available when you receive them from an out-of-area provider.

UPMC Vision Care provides discounted pricing on additional lens options, such as coatings, polarization, and other lens add-ons. A Copayment may apply for these additional services. Refer to your Pediatric Vision Schedule of Benefits and Additional Lens Options document for plan-specific benefit information.



**Frames:** Frames reimbursement is based on retail allowance and a percentage of the provider's agreed-upon reimbursement. Please refer to your Pediatric Vision Schedule of Benefits. Select any frame from the Participating Vision Providers inventory of collection frames, not exceeding \$100, which are covered at 100 percent. Any frames not included in the collection and in excess of your plan allowance is your responsibility. 20 percent discount may apply to amounts exceeding the plan and allowance and may vary by Participating Vision Provider. Eligible Members are entitled to one frame every 12 months.

**Contact lenses (if deemed medically necessary):** Medically Necessary contact lenses are covered at 100 percent with Prior Authorization when prescribed for a qualifying ocular condition. Contact lenses are only covered if deemed Medically Necessary by UPMC Vision Care, once every 12 months from the last date of service. This may include:

- A separate allowance for the fitting fee (standard or comprehensive)
- Lens material

The contact lens benefit includes all types of contact lenses, such as hard, soft, gas permeable, and disposablenses, in lieu of eyeglasses.

UPMC Vision Care also offers Members an interim discount benefit through the NVA EYEESSENTIAL Plan®. Refer to your plan documents for discounts on exams, lenses for eyeglasses, frames, and contact lenses. If Members choose additional options not specified in their plan documents, they are responsible for the additional cost of the options to be paid to the provider directly. Not all providers participate in the discount plan. To locate a participating NVA EYEESSENTIAL Vision provider, visit our website at [www.upmchealthplan.com](http://www.upmchealthplan.com) or call the Health Care Concierge team at 1-844-252-0687 for assistance.

**Any add-ons or treatments not listed on your Pediatric Vision Schedule of Benefits, additional lens options, or NVA EYEESSENTIAL documents are not covered by or to be billed to UPMC Vision Care.**

### **Replacement eyeglass program**

Members who require replacement of broken eyeglasses (frames and/or lenses) may receive such replacement, with prior Authroization from the Plan. The replacement frames and/or lenses are considered a lifetime benefit, payable once per eligible Member, available to you. Replacements must be of the same frame (if still commercially available), lens type, material, and prescription. Only those parts (frame or lenses) requiring replacement will be replaced, and it may be necessary to return the frame to the laboratory in order to have the new lenses installed. Replacement eyeglasses will only be covered up to the plan maximum. Any costs exceeding the plan maximum, including the cost for replacing any lens options that may have been originally purchased, such as special coatings, progressive lenses, etc., will be the responsibility of the Member. Contact lenses are not covered by replacement policy. This replacement eyeglass policy applies to eyeglasses broken accidentally, after receipt and acceptance by the Member. In instances in which minor repairs may be made (For example:missing nose pads, missing screws), the Member may be ( charged a \$5 repair fee and may not apply when a Nonparticipating Vision Laboratory is used. Replacement and repair policy may not apply or vary when receiving services from a Nonparticipating Vision Laboratory. Please consult with your vision provider regarding their replacement/repair policy.

Replacement and repair policy may not apply or vary when receiving services from a Nonparticipating Vision Laboratory. Please consult with your vision provider regarding their replacement/repair policy.

**UPMC Vision Care policy on nonadapts for Members with progressive addition lenses (PALS) and digital single vision lenses**

On occasion, individuals receiving progressive addition lenses or certain types of digital single vision lenses experience difficulty in adapting to this new lens technology, even though the prescription is correct, and the Member is properly fitted. The industry considers this to be a “nonadapt” situation, for which the UPMC Vision Care Program provides protection in the form of the following warranty.

Any Member who is unable to adapt to a PAL or digital single vision lens will be offered a replacement pair of conventional single vision, bifocal, or trifocal lenses into the same frame at no charge. The replacement lenses must be the same material and prescription as the original lenses and will include, at no additional charge, any lens options for which you previously paid a fee. Please note that any amount you paid for the original lenses is not refundable, so be sure that you discuss your visual needs and likelihood of success in wearing these lenses with your provider before placing your order.

This warranty is valid for up to 90 days from the receipt of your eyeglasses and may not apply when a Nonparticipating Vision Laboratory is used.

**Pediatric Vision Schedule of Benefits**

Your benefits are shown on the Pediatric Vision Schedule of Benefits included in this packet. The Pediatric Vision Schedule of Benefits shows:

- The classes of vision services covered, shown with the Maximum Allowable Charge that the Plan pays for those services.
- Any of your out-of-pocket costs or cost sharing for a Covered Service.
- Any Copayments that must be paid per Benefit Period before any Covered Services will be paid by the Plan.
- Any limits for Covered Services for a given period of time; for example, annual limitations on lenses. Annual limits are applied on a Benefit Period basis.

**Your out-of-pocket costs**

In order to keep the Plan affordable for you, the Plan includes certain cost-sharing features. If the class or service grouping is not covered under the Plan, the Pediatric Vision Schedule of Benefits will indicate “not covered.” You will be responsible to pay your vision provider the full charges for services that are not Covered Services.

**Schedule of Exclusions**

No benefits will be provided for services, supplies, or charges detailed in the Schedule of Exclusions

# Claims

## Claims submissions

If you receive care from a Participating Vision Provider, you should not have to submit a claim to the Plan. The Participating Vision Provider will bill the Plan, and the Plan will pay the provider directly. However, if you obtain Covered Services from a Nonparticipating Vision Provider, you may have to file a claim yourself. To submit a claim, follow the steps below.

To obtain an out-of-network claim form, log in to *MyHealth OnLine* via [www.upmchealthplan.com](http://www.upmchealthplan.com) or contact UPMC Vision Care at 1-844-252-0687. Be sure to include the following on the claim form:

- Member's name
- Member's date of birth
- Policyholder's Social Security number
- Policyholder's name and address
- The name and policy number of a second insurer if the Member is covered by another vision plan
- Proof of payment (if no proof of payment, the Member will need to include detailed information regarding the service – provider name, address, date of service, and amount charged)

Claim forms should be sent to:

UPMC Vision Care  
PO Box 106039 Pittsburgh,  
PA 15230-6039

Remember, a request for payment of a claim will not be reviewed and no payment will be made unless all of the information described above has been submitted to the Plan. The Plan reserves the right to require additional information and documents, if necessary, to support your claim. Should you have any questions concerning your coverage or eligibility or a specific claim, contact UPMC Vision Care at 1-844-252-0687 or log in to *MyHealth OnLine* at [www.upmchealthplan.com](http://www.upmchealthplan.com).

## Notice of claim

The Plan will not be liable under this Certificate unless proper notice is furnished to the Plan that Covered Services in this Certificate have been rendered to you. Written notice must be given to the Plan within 20 days following the date in which the Covered Services were rendered or as soon as reasonably possible thereafter. You must give notice to the Plan in writing at UPMC Vision Care, PO Box 106039, Pittsburgh, PA 15230-6039. The notice must include the data necessary for the Plan to determine benefits. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

## Claim forms

Proof of Loss for benefits under this Certificate must be submitted to the Plan on the appropriate claim form. The Plan, upon receipt of notice of claim, will, within 15 days following the date the notice of a claim is received, furnish claim forms to the Member for filing proofs of loss. If claim forms are not furnished within 15 days after the giving of such notice, you shall be deemed to have complied with the requirements of this subsection as to filing a Proof of Loss upon submitting, within the time fixed in this subsection for filing proofs of loss, itemized bills for Covered Services as described below. The Proof of Loss may be submitted to the Plan at the address shown on the out-of-network claim form.

**Proof of Loss**

Written Proof of Loss must be furnished to the Plan within 90 days after the date of such loss. Failure to give notice to the Plan within the time required will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no case, except in the absence of legal capacity, will the Plan be required to accept notice later than one year after the end date in which the Covered Service was rendered.

**Timely payment of claims**

Subject to due written Proof of Loss, all claims payable under this Certificate will be paid immediately, according to any applicable regulatory requirements. For submitted claims, the Plan will not be liable under this Certificate unless proper notice is furnished to the Plan that Covered Services have been rendered to an insured.

UPMC Vision Care will not be responsible for payment of claims for Covered Services that are submitted more than one year from the date of service.

**Payment of claims**

Claims payable under this Certificate when loss of life has occurred will be payable in accordance with the beneficiary designation and the provisions respecting such payment, which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, claims shall be payable to the estate of the insured. Any of other accrued claims unpaid at the insured's death may, at the option of the Plan, be paid either to such beneficiary or to such estate. All other claims will be payable to the insured.

**Payment of benefits**

If you have treatment performed by a Participating Vision Provider, we will pay Covered Benefits directly to the Participating Vision Provider. Payment will be based on the Maximum Allowable Charge that the treating Participating Vision Provider has contracted to accept and what your benefit allows.

If you receive treatment from a Nonparticipating Vision Provider, we will send payment for Covered Benefits to you unless otherwise indicated on the claim form. Both you and the vision provider will be notified of the Plan payment and any amounts you owe for charges exceeding limits or denial of noncovered services. The Plan payment will be based on the Maximum Allowable Charge for the services. You will be responsible to pay the vision provider any difference between the Plan's payment and the vision provider's full charge for the service. A Member's right to reimbursement for any Covered Service is not assignable.

**Change of beneficiary**

The right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to the surrender or assignment of this Certificate or to any change of beneficiary or beneficiaries, or to any other changes in this Certificate.

**Overpayments**

If we make an overpayment for benefits, we have the right to recover the overpayment. In the event that overpayment was made to the Member, we will recover the overpayment by requesting a refund. In the event that overpayment was made to the provider, we will recover the overpayment by either requesting a refund or offsetting the amount overpaid from future claim payments. Recovery will be done in accordance with any applicable state laws or regulations.

### **Coordination of benefits**

When you or your covered dependents are eligible for coverage under more than one vision plan, the Plan will coordinate your benefits with those plans. The Plan does this to make sure that your benefits will be paid appropriately while preventing duplicate payments. This is how coordination of benefits works for your benefit plan:

- When your other coverage does not mention “coordination of benefits,” then that coverage pays first. Benefits paid or payable by that coverage will be taken into account when we determine if additional benefit payments can be made under this Plan.
- When you are covered as an employee under one plan and as a dependent under another, the employee coverage pays first.
- When the dependent child is covered under two plans, the plan covering the parent whose birthday occurs earlier in the calendar year pays first. If both parents have the same birthday, then the plan under which one parent was covered longest pays first.
- If the dependent child’s parents are separated or divorced and:
  - o The parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
  - o The parent with custody has remarried, the coverage of the parent with custody pays first, but the stepparent’s coverage, if any, pays before the coverage of the parent without custody.
  - o There is a court order that specifies the parent who is financially responsible for the child’s vision expenses, the coverage of that parent pays first.
- If the service is also covered under the medical plan in which the Member may be enrolled in, the medical plan pays first. If it is a covered vision benefit, vision coverage will be considered the secondary payer. When none of the above circumstances applies, the coverage that you have had the longest applies first, as long as:
  - o The benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person; and
  - o The other plan does not have a provision regarding laid-off or retired employees and, therefore, the benefits of each plan are determined after the other, then the provisions listed above shall not apply.

If you or your vision provider receive more than you should have when your benefits are coordinated, you or your vision provider will be expected to repay the overpayment.

It is the policy of UPMC Vision Care to review all other insurance coverage prior to releasing a claim for payment. If other insurance coverage is found after a payment has been made, a review will determine which plan pays first and what action will be taken in regard to any claims in question. Whenever payments should have been made by the Plan, but the payments have been made under another benefit plan, UPMC Vision Care has the right to pay to the benefit plan that has made such payment any amount that the Plan determines to be appropriate under the terms of this Certificate. Any amounts paid shall be considered to be benefits paid in full under this Certificate.

If the Plan makes payment for Covered Services in excess of the amount of payment pursuant to this Certificate, irrespective of to whom those amounts were paid, UPMC Vision Care shall have the right to recover the excess amount from any person or entity to or for whom such payments were made. Upon reasonable request by the Plan or its agent, you must execute and deliver such documents as may be required and do whatever else is reasonably necessary to secure UPMC Vision Care’s rights to recover the excess payments.

UPMC Vision Care is not required to determine whether or not you have other vision benefits or insurance or the amount of benefits payable under any other vision benefits or insurance. The Plan shall only be responsible for coordination of benefits to the extent that information regarding your other insurance is provided to the Plan by you, your employer or plan sponsor, another insurance company, or any other entity or person authorized to provide such information.

**Workers' compensation**

When a Member is eligible for workers' compensation benefits through employment, the cost of vision treatment for an injury that arises out of and in the course of a Member's employment is not a Covered Benefit under this Plan. If the Plan pays for services that are covered by a workers' compensation policy, the Plan has the right to obtain reimbursement for those benefits paid. The Member must provide any assistance necessary, including furnishing information and signing necessary documents, for the Plan to receive the reimbursement

**Review of a benefit determination**

If you are not satisfied with the Plan's benefit, please contact us at 1-844-252-0687. If, after speaking with our Health Care Concierge team, you are still dissatisfied, refer to the "Resolving Disputes with the Plan" subsection for further steps you can take regarding your claim.

## Resolving Disputes with the Plan

At times you may not be satisfied with a decision that the Plan makes regarding your coverage or with the vision services you have received. As a Member of UPMC Vision Care, you have the right to file a Complaint.

### **The Complaint process**

A Member with a Complaint about a Participating Vision Provider, coverage, operations, or the Plan's management policies should contact our Health Care Concierge team at 1-844-252-0687. TTY users should call 711.

You may appoint in writing a representative to act on your behalf. In addition, you or your representative may request the help of a Plan employee who has not taken part in the decision to deny coverage or the issue in dispute. That employee will assist you in preparing the Complaint at no charge to you. Complaints must be filed with UPMC Vision Care within 180 days from denial notification or of the occurrence.

There is one step in the internal Complaint process — the initial review, which is described in this section.

### **Initial review**

#### **1. You file a Complaint.**

Complaints may be verbal or in writing and may include documentation. The Complaint should indicate the remedy or corrective action being sought. For example, a Complaint may deal with a claim denial, and the remedy being sought is payment of the claim. All written Complaints should be submitted to:

UPMC Vision Care  
Member Complaints  
PO Box 2939  
Pittsburgh, PA 15230-2939

Verbal Complaints can be made to our Health Care Concierge team by calling 1-844-252-0687. TTY users should call 711.

#### **2. UPMC Vision Care acknowledges the Complaint.**

The Plan sends a letter to you within five business days stating that it has received the Complaint.

#### **3. The Initial Complaint Review Committee investigates the Complaint.**

The committee, which consists of one or more Plan employees, investigates the Complaint.

#### **4. The committee makes a decision and notifies you.**

The committee makes a decision within 30 calendar days of receiving a Complaint. The committee notifies you in writing within five business days of making its decision, giving its reasons and the Member's appeal rights, if applicable.

## Schedule of Exclusions

### What is not covered?

Not all vision services are Covered Services. The following is a list of services that are not covered under your benefit plan. If you are not sure if a service is covered, call us at 1-844-252-0687 to ask if that service is covered under your benefit plan.

- **Blood:** Nonpurchased blood or blood products, including autologous donations.
- **Cosmetic surgery:** Surgical or other services performed solely for cosmetic reasons — to repair or reshape a body structure for the improvement of the person's appearance or for psychological or emotional reasons and from which no improvement in physiological function can be expected.
- **Court-ordered services:** Court-ordered services when your vision provider or other professional provider determines that those services are not appropriate to vision treatment.
- **Employment-related or employer-sponsored services:**
  - A. For any illness or bodily injury that occurs in the course of employment, if benefits or compensation is available in whole or in part, pursuant to any federal, state, or local government's workers' compensation, or occupational disease, or similar type of legislation. This exclusion applies whether or not you claim those benefits or compensation.
  - B. Services that you receive from a vision or medical department, operated in whole or in part by, or on behalf of, an employer, mutual benefit association, labor union, trust, or similar entity.
- **Experimental/Investigational:** Services that are experimental/investigational in nature as determined by the Plan.
- Medical/vision services not identified as "covered" in this Certificate: Any other medical or vision service or treatment, except as provided in this Certificate or as mandated by law.
- **Medicare:** Services for which or to the extent that payment has been made pursuant to Medicare coverage, when Medicare coverage is primary.
- **Military service:**
  - A. Care for military service-connected disabilities and conditions for which you are legally entitled to services and for which facilities are reasonably accessible to you.
  - B. Services that are provided to Members of the armed forces and the National Health Service or to individuals in Veterans Administration facilities for military service-related illness or injury, unless you have a legal obligation to pay.
- **Miscellaneous:** Any services, supplies, or treatments not specifically listed in the Certificate as Covered Benefits, services, supplies, or treatments, unless they are a basic vision service.
  - A. Any services related to or necessitated by an excluded item or noncovered service.
  - B. Services provided by a nonlicensed practitioner.
  - C. Services that are primarily educational in nature.
  - D. Services incurred after the date of termination of your coverage, except as provided elsewhere in this Certificate.
  - E. Services rendered before the effective date of your coverage.
  - F. Services for which you otherwise would have no legal obligation to pay.
  - G. Charges for telephone consultations unless otherwise allowed in accordance with Plan policy.
  - H. Charges for failure to keep a scheduled appointment.
  - I. Services performed by a vision provider enrolled in an education or training program when such services are related to the education or training program.
  - J. Charges for completion of any insurance form or copying of vision or medical records.
  - K. Services that are submitted by two different vision providers for the same services performed on the same date for the same individual.
  - L. Services for, or related to, any illness or injury suffered after the effective date of your



coverage that is the result of any act of war.

- M. Services that are more than the maximum allowable fee schedule amount.
- N. Charges for vision care that is not deemed necessary.
- O. Expenses incurred by you to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. The Plan will take into account any adjustment option chosen under such part by you.
- P. Vision examination or materials required for employment.
- Q. Replacement of lost, stolen eyewear (glasses or contact lenses), broken or damaged lenses, unless otherwise stated in plan documents. NVA network providers may offer additional warranties to cover materials unless otherwise stated in plan documents.
- R. Contact lenses or frames except at normal intervals when service would otherwise be available.
- S. Services or materials provided by federal, state, local government or workers' compensation.
- T. Industrial safety lenses and safety frames with or without side shields.
- U. Parts or repair of frame/sunglasses.
- V. Replacement of a lost or stolen appliance.
- **Motor vehicle accident/workers' compensation:** Treatment or services for injuries resulting from the maintenance or use of a motor vehicle to the extent such treatment or service is paid or payable under a motor vehicle insurance policy, or any injury sustained in the course and scope of performing work for which coverage is afforded under a workers' compensation policy, including, but not limited to, a qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical or vision benefits established by law, including medical benefits payment in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act or equivalent law of another state.
- **Prescription drugs.**
- **Professional services and/or materials in connection with:**
  - Plan (non-prescription) lenses.
  - Aniseikonic lenses.
  - Subnormal visual aids.
  - Orthoptics, vision training, developmental vision procedures, and any associated supplemental testing.
- **Two pairs of glasses in lieu of bifocals.**

## **General Provisions**

This Certificate includes and incorporates any and all Schedule of Benefits and, together, the Pediatric Certificate of Insurance and Pediatric Vision Schedule of Benefits represent the entire agreement between the parties with respect to the subject matter. The failure of any section or subsection of this Certificate shall not affect the validity, legality, and enforceability of the remaining sections.

Except as otherwise herein provided, this Certificate may be amended, changed, or modified only in writing by the Plan and thereafter attached hereto as part of this Certificate.

The Plan may assign this Certificate and its rights and obligations hereunder to any entity under common control with the Plan.

The pertinent laws and regulations for interpretation and enforcement of the Certificate are the laws and regulations of the Commonwealth of Pennsylvania.

### **Entire contract; changes**

Subject to the contract between your employer and the Plan (if applicable), this Certificate, including the schedules, riders, and other documents attached hereto and issued in accordance herewith, represents the entire contract of insurance between you and the Plan. No agent or representative of the Plan other than a Health Plan officer may otherwise change this Certificate or waive any of its provisions. All statements you made will, in the absence of fraud, be deemed representations, and not warranties, and no such statement will be in defense to a claim under this Certificate, unless it is contained in a written instrument signed by and furnished to you.

### **Misstatement of age**

If your age has been misstated, all amounts payable under the plan shall be the premium amount owed if the plan had been purchased at the correct age. The Plan shall notify you of the correct premium amount on immediately following its discovery of the error. The correct premium amount shall also be applied retroactively, which may result in you owing additional premium amounts as of the Effective Date of your Certificate.

### **Physical examinations**

The Plan, at its own expense, shall have the right and opportunity to examine the Member when and as often as it may reasonably require during the pendency of a claim hereunder.

### **Legal actions**

No action in law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after written Proof of Loss has been filed in accordance with the requirements of the policy. No such action shall be brought after the expiration of three years after the time written Proof of Loss is required to be furnished.

### **Time Limit on Certain Defenses**

After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in this policy) commencing after the expiration of such three-year period.

### **Reinstatement**

If your coverage under this Certificate has been terminated for failure to pay premiums, the Plan will reinstate your coverage as long as the premium due is paid in full within 30-calendar days after the end of the grace period. The reinstated Certificate shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

**Fraud and abuse**

According to Pennsylvania statute:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The Plan is committed to ensure the integrity of, provision of, and payment for Covered Services that are deemed necessary to our members. If you suspect that a UPMC Vision Care Member or provider is committing fraud or abuse, contact our Special Investigations Unit at 1-866-FRAUD01 (1-866-372-8301) or [specialinvestigationsunit@upmc.edu](mailto:specialinvestigationsunit@upmc.edu).

## UPMC HEALTH PLAN

U.S. Steel Tower, 600 Grant Street  
Pittsburgh, PA 15219

[www.upmchealthplan.com](http://www.upmchealthplan.com)



# Nondiscrimination notice

UPMC Health Plan, on behalf of itself and its affiliates, complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex, gender, gender identity or expression, or sexual orientation.

UPMC Health Plan provides free aids and services to people with disabilities so that they can communicate effectively with us. Aids and services may include:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

UPMC Health Plan provides free language services to people whose primary language is not English. Language services may include:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact the Member Services phone number listed on the back of your member ID card.

If you believe that UPMC Health Plan has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression, you can file a complaint with:

Complaints and Grievances  
PO Box 2939  
Pittsburgh, PA 15230-2939

Phone: 1-888-876-2756 (TTY: 711)  
Fax: 1-412-454-7920  
Email: [HealthPlanCompliance@upmc.edu](mailto:HealthPlanCompliance@upmc.edu)

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019. TTY/TDD users should call 1-800-537-7697.

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

# Translation services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-869-7228 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-869-7228 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-869-7228 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-869-7228 (телетайп: 711).

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-869-7228 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-869-7228 (TTY: 711) 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-869-7228 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-869-7228 (رقم هاتف الصم والبكم: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-869-7228 (ATS: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-869-7228 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-869-7228 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-869-7228 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-869-7228 (TTY: 711).

សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ យើងមានផ្តល់សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខ 1-855-869-7228 (TTY: 711)។

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-869-7228 (TTY: 711).