

Duke Vision Program

Coverage provided and underwritten
by UnitedHealthcare Vision





Duke Vision Program

The coverage for the Duke Group Vision Insurance Program is provided and underwritten by UnitedHealthcare Vision. While Duke's health plans provide coverage for annual eye exams, Duke offers a nationwide vision care plan to manage the cost of eyeglasses and contact lenses, as well as eye examinations. The vision care plan provides coverage for prescription lenses and frames, contact lenses (in lieu of eyeglasses), and a complete annual eye exam. Spectra participants also receive access to discounted refractive eye surgery from numerous provider locations throughout the United States, through The Laser Vision Network of America.

Under the plan, you can visit an optometrist or ophthalmologist within the Unitedhealthcare Vision network or you may choose to visit an out-of-network provider, which may result in higher out-of-pocket costs. If you have questions about the vision care plan or would like to find a network provider, you may visit www.MyUHCSpecialtyBenefits.com or call 1-800-638-3120.

The term "Duke" is used throughout this document. For purposes of this Benefit Program description, "Duke" refers to the University, Duke University Health System, Inc., and any other entity which is or becomes controlled by Duke University and where, upon appropriate action by the Board of Trustees, the employees of that entity are included in the membership of this program.

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Eligibility and Enrollment

Eligibility

You are eligible for vision coverage if you are a:

- Regular employee who works at least 20 hours per week and who is included in a payroll/benefit classification designated by Duke as eligible to apply for coverage under the Group Vision Insurance Program.

Eligible Dependents

The following dependents are eligible for enrollment in the Duke Vision Program:

- Your legal spouse or same-sex spousal equivalent,
- Your unmarried dependent children (includes natural children, stepchildren, adopted children, foster children, or children for whom you are legal guardian up to age 19, or up to the 26th birthday if unmarried, full-time students. Dependent children does not include grand-children, siblings, or other family members, or children of whom you have legal custody), and
- Your children who are mentally or physically disabled and incapable of self-support after age 19, as long as:
 - Their disability began before they turned age 19,
 - They had continuous coverage under the Duke vision plan prior to age 19, and
 - A handicapped dependent form is submitted to and approved by the Vision Plan prior to the 19th birthday.

Collective Bargaining Agreements

Group vision insurance benefits are a subject of good faith bargaining between Duke and certain employee representatives. The plan is maintained pursuant to certain collective bargaining agreements. The agreements are available for your inspection in the Staff and Labor Relations Department of Duke's Human Resources, 144 Trent Drive Hall, Durham, NC.

Enrolling

You have 60 days from the date of employment to enroll in the Group Vision Insurance Program.

If you do not enroll when you are first eligible (within 60 days of employment or eligibility), you can enroll during the annual Open Enrollment period.

There are several types of coverage in which you may enroll:

- Employee Only Coverage (Individual)
- Employee and Spouse/Same-Sex Spousal Equivalent
- Employee and Child
- Employee and Children
- Family

PLEASE NOTE: Once you enroll in a particular type of coverage, you cannot stop or change your election until the next annual Open Enrollment period, unless you experience a qualifying event. Qualifying events include, but are not limited to, birth, marriage, divorce, death of a spouse or child, or termination of employment.

Effective Date of Coverage

New employees of Duke University and Duke University Health System are eligible for coverage effective on:

- First day of employment/eligibility with Duke, or
- First day of the second month of employment/eligibility.

When Coverage Ends

Member Terminations

Your membership in the Plan, and coverage under the Plan, may be terminated and written notice will be provided for any of the following reasons:

- Fraud or misrepresentation. This includes but is not limited to fraudulent statements or material misrepresentations of fact made on your enrollment application, including enrollment of ineligible dependents;
- Fraudulent use of services or facilities;
- Misuse of your coverage. This includes but is not limited to allowing someone else to use your Plan coverage eligibility; or
- Nonpayment of your contribution toward coverage under the Plan.

The Plan is entitled to recover all expenses it incurs (including the reasonable value of services received, reasonable attorney's fees and any incidental expenses) because of fraud, misuse or misrepresentation from the member who committed such fraud, misuse or misrepresentation.

Termination of Coverage

Members may not terminate coverage under the Plan except during the annual Open Enrollment period or within 30 days of a valid change in family status.

Subject to your continuation rights under COBRA, your Plan coverage will terminate if you lose your eligibility to be a member, or if the employee through whom you are enrolled in the Plan loses his/her Plan coverage. If you cease to be eligible to participate in the Plan because of an amendment to the Plan by Duke University, your coverage will terminate the date the amendment to the Plan takes effect. Coverage for all the members enrolled through an employee who loses his or her eligibility because of a Plan amendment will terminate the date the amendment takes effect. Coverage for all Plan members will terminate as of the date Duke terminates the Plan.

Cost of the Plan

Eligible employees covered under the plan pay the entire premium for their benefits under the plan in such amounts as determined solely by the insurance company, UnitedHealthcare Vision. Premium payments are required to be paid on a before-tax basis through the Duke University Premium Conversion and Flexible Reimbursement Accounts Plan.

How the Vision Program Works

Vision Care Plan Chart

Benefits	Network Benefits	Out-of-Network Reimbursement
Vision Exam (once every 12 months)	\$15 co-pay	\$40
Materials Co-pay ¹	\$15 co-pay	Not applicable
Frames (once every 24 months)	Covered-in-full (up to \$50 wholesale or \$130 retail) ²	\$45
Eyeglass Lenses per pair (once every 12 months) Single Vision Bifocal Trifocal Lenticular	Covered-in-full Covered-in-full Covered-in-full Covered-in-full	\$40 \$60 \$80 \$80
Lens Options Standard (including but not limited to progressive, polycarbonate, tints, UV coating, anti-reflective coating, photochromatic, transition and edge coating)	Covered-in-full	Included as part of the Eyeglass Lenses reimbursement schedule listed above.
Specialty (including but not limited to high index, high density)	May be available at a discount	
Contact Lenses⁴ – in lieu of eyeglasses (including evaluation, fitting, and up to two follow-up visits) Elective Covered-in-full lenses (including but not limited to Acuvue by Johnson & Johnson, Optima by Bausch & Lomb) All other elective lenses (including but not limited to toric, gas permeable, bifocal)	Covered-in-full ⁴ including evaluation, fitting, and up to two follow-up visits Up to \$150 allowance towards the fitting/evaluation fees and lenses purchase (materials co-pay does not apply)	\$150 \$150
Necessary ³	Covered-in-full	\$210

1 Materials co-pay is a single payment that applies to the purchase of eyeglass lenses and frames or contact lenses (in lieu of eyeglasses). All contact lenses must be purchased at one time.

2 Receive a \$50 wholesale frame allowance at a private practice provider or a \$130 retail frame allowance at a retail chain provider (a corporately-owned provider that uses their own lab and materials).

3 Determined at the provider's discretion for one or more of the following conditions: following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact Spectera concerning the reimbursement that Spectera will make before you purchase such contacts.

4 Benefit covers up to 6 boxes (which must be purchased at the same time).

Accessing and Using Your Benefits

UnitedHealthcare Vision does not send out identification cards to enrolled members. However, the steps listed below will help you access your vision benefits.

Step 1: Review Your Benefits

A summary of the benefits offered under the vision care plan are available in the Vision Care Plan Chart located on the previous page.

Step 2: Find a Provider

You may locate a UnitedHealthcare Vision network provider by logging on to www.MyUHCSpecialtyBenefits.com or by calling their 24-hour, toll-free provider locator service at (800) 638-3120. You may also choose to use an out-of-network provider and still receive benefits under the plan. Details about submitting an out-of-network claim are located on the next page.

Step 3: Schedule Your Appointment

Always identify yourself as a UnitedHealthcare Vision participant when making an appointment with a UnitedHealthcare Vision provider. This will assist your provider in obtaining a claim authorization number before your visit. Provide the primary insured's Duke Unique ID (a seven digit number located on the back of your Duke ID card) and patient's name and date of birth.

Step 4: Your Eye Exam

The network provider, a state-licensed optometrist or ophthalmologist, will perform a complete eye examination, which includes a case history of the patient, an examination for eye pathology and abnormalities, visual analysis (refraction), diagnosis and prescription, and visual skill testing.

PLEASE NOTE: If you wish to use an out-of-network provider for your eye exam, you may take your prescription to a UnitedHealthcare Vision network provider for your glasses or contact lenses.

If you are enrolled in one of Duke's health plans, you can continue to receive coverage for an annual eye exam with the health plan's co-pay. UnitedHealthcare Vision will reimburse you for

your health plan's vision examination co-pay if you visit a provider outside of UnitedHealthcare Vision's network. Details about submitting an out-of-network claim are located on the next page.

The Duke Eye Center does not participate in the UnitedHealthcare Vision network. An exam is covered under all of the Duke Health Plans, and the co-pay cost filed with UnitedHealthcare Vision.

Step 5: Your Eyewear

If prescription eyewear is necessary, your UnitedHealthcare Vision provider will assist with your selection and order your prescription. Your UnitedHealthcare Vision provider will telephone you when your eyewear arrives. Eyewear is dispensed at the provider's office to ensure optical accuracy and proper fit.

Ineligible Expenses

The following services and materials are excluded from coverage under the vision care plan:

- Post cataract lenses
- Non-prescription items
- Medical or surgical treatment for eye disease that requires the services of a physician
- Workers' Compensation services or materials
- Services or materials that the patient, without cost, obtains from any governmental organization or program
- Services or materials that are not specifically covered by the policy
- Replacement or repair of lenses and/or frames that have been lost or broken
- Cosmetic extras, except as stated in the policy

Continuation of Benefits

If you are covered by the Group Vision Insurance Program at the time you leave Duke, you may continue coverage under the following circumstance:

- Upon termination or change in eligibility, you may continue coverage under COBRA for you and your covered dependents.

How to File a Claim

Out-of-Network Claims Procedure

If you choose an out-of-network provider, you must submit the following information:

- The original itemized paid receipt
- Primary insured's name and Duke Unique ID number (a seven digit number located on the back of your Duke ID card)
- Patient's name and date-of-birth
- Complete home address

Out-of-network claims should be sent to:

UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, Utah 84130

PLEASE NOTE: Receipts for services and materials purchased on different dates must be submitted together to receive reimbursement. Claims must be submitted within 12 months of the date of service to be eligible for reimbursement.

Claims Review Procedure

Since network providers must receive preauthorization to perform services prior to the scheduled appointment, denied claims rarely occur. However, if a submitted claim is denied, and if the member wishes to appeal, the appeal must be submitted in writing, within 60 days of the date of the Explanation of Benefits, to:

UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, Utah 84130
Attention: Claims Appeals

If the member decides to appeal, they have the right to review any pertinent information, and then submit issues and comments in writing. The claim will

then be reconsidered, and the member will receive written notice of the determination within 60 days. If the claim is again denied, in whole or in part, the member will receive a written explanation of the denial and the program, or contract provision, on which the denial is based. All levels of UnitedHealthcare Vision's appeals process are ERISA compliant, and follow the Department of Labor laws regarding ERISA appeal and grievance information.

Appeals of Eligibility, Right to Participate, and Other Claims Not Directly Related to Benefit Payments

With respect to all claims or issues not subject to the claims procedures described for the plan, such as your right as an eligible employee or dependent to apply for coverage under the plan, you may make a claim by filing a written claim and proof of claim with the Plan Administrator in accordance with procedures and guidelines established from time to time by the Staff Fringe Benefits Committee (the Committee). The Plan Administrator will decide whether the claim will be allowed. Send your claim to:

Vision Plan Administrator
Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708

Within 90 days after receipt of a proof of claim by the Plan Administrator, as appropriate, or within 180 days if special circumstances require an extension of time, you will be notified of the decision with regard to your claim. In the event of special circumstances requiring an extension of time, written notice of the extension will be furnished to you prior to expiration of the 90-day period, setting forth the special circumstances and the date the decision will be furnished. If the claim is wholly or partially denied, notice thereof will be in writing

and worded in a manner for you to understand. Such notice will set forth:

- The specific reason(s) for the denial,
- Specific reference to pertinent plan provisions on which the denial is based,
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, and
- An explanation of the procedure for review of the denied claim.

If you are not notified of the decision concerning your claim in a timely manner, the claim will be deemed denied as of the close of the initial 90-day period (or the close of the extension period, if applicable). If you wish to appeal the denial, follow the instructions below.

Claims Review Procedure

Within 60 days following your receipt of notice from the Plan Administrator denying the claim in whole or in part or, if such notice is not given, within 60 days following the latest date on which such notice could have been timely given, you may appeal the denial of the claim by filing a written application for review with the Committee.

Send your appeals to:

**Staff Fringe Benefits Committee
Duke Benefits
705 Broad St.
Box 90502
Durham, NC 27708**

Following such request for review, your appeal of the decision denying your claim will be fully and fairly reviewed. Prior to reaching a decision concerning your appeal, you will be given an opportunity to review pertinent documents and submit issues and comments in writing.

The decision on review of a claim denied in whole or in part will be made within 60 days following receipt of the request for review, or within 120 days if special circumstances require an extension of time, and you will be notified in writing of the decision. If special circumstances require an extension of time, written notice of the extension will be furnished to you prior to commencement of the extension. If the decision on review is not furnished in a timely manner, your claim will be deemed denied as of the close of the initial 60-day period, or the close of the extension period, if applicable.

If a claim is denied in whole or in part, the decision on review will set forth specific reasons for the decision written in a manner for you to understand, and will cite pertinent plan provisions on which the decision is based. The decision on review of your claim by the Committee will be final and conclusive.

Any action required to be taken by you during the claims procedure or claims review procedure may be taken by a representative acting on your behalf. You may be required to provide evidence to verify the authority of any such representative to act on your behalf. Neither you nor your representative has the right to be present during the consideration of any appeal from the initial denial of your claim.

Authority of the Committee and the Plan Administrator

Both the Committee and the Plan Administrator have the duty and discretionary authority to interpret and construe the eligibility provisions of the plan, subject to the objective terms of the plan. Interpretations and determinations made by the Committee and the Plan Administrator will be applied uniformly to all persons similarly situated and will be binding and conclusive upon each eligible employee and dependent who is covered under the plan and any other interested person. Such interpretations and determinations made by the Committee and the Plan Administrator will only be overruled by a court of law if the Committee and the Plan Administrator are found to have acted arbitrarily and capriciously in interpreting and construing the provisions of the plan.

Other Information

See the “General Information” section of this booklet for:

- A summary of your rights under the Employee Retirement Income Security Act of 1974 (ERISA),
- Information about COBRA continuation coverage, and
- Administrative and other general information about this plan.

It is intended that the Duke Vision Program qualify as an “accident and health plan” under federal tax laws. This Benefit Program Description, which is a part of the Duke University Welfare and Fringe Benefit Plan along with the underlying insurance contracts, shall constitute the written plan document for the Duke Vision Program. It is further intended that benefits payable under the Duke Vision Program be eligible for exclusion from gross income. Duke reserves the right to change or terminate these benefits or your eligibility for benefits under the Duke Vision Program. The written plan documents for the Duke Vision Program are not employment contracts or any type of employment guarantee.