



## **Delaco Steel Corporation**

### Your Vision Plan

Policy No. 967884 011

Underwritten by Starmount Life Insurance Company

7/5/2024





**Starmount Life  
Insurance Company**  
8485 Goodwood Blvd.  
Baton Rouge, LA 70806

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## Group Vision Insurance Certificate of Coverage

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We welcome you as a customer and are committed to providing quality service. This is your Certificate of Coverage and describes the benefits for which you are insured. Vision insurance may help reduce costs for routine preventative eye care and prescription eyewear.

**Policyholder:** Delaco Steel Corporation

**Policy Number:** 967884 011

**Policy Effective Date:** July 1, 2024

**Policy Anniversary:** January 1

**Governing Jurisdiction:** Michigan

This Certificate is issued to you under the Policy which is a contract between us and the Policyholder. If the terms and provisions of this Certificate are different from the Policy, the Policy will govern. A copy of the Policy may be made available to you upon request. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

All references to provisions, sections, and defined terms found within this Certificate have been capitalized. If you have any questions about the terms and provisions of this Certificate, please contact your Employer or us.

**This Certificate of Coverage provides benefits under the non-participating Policy. This Certificate contains certain proof of loss requirements, limitations, and exclusions that may prevent an Insured from receiving benefits under this Certificate. Please read your Certificate carefully and keep it in a safe place.**

Your certificate includes notices as required by your state of residence that may impact your benefits. If you have any questions or concerns regarding your state regulations, you may contact the Department of Insurance and Financial Services at (877) 999-6442.

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This section includes highlights of an Insured's coverage. Please refer to the **Vision Details** for further information on the benefits available.

**Eligible Group(s)**

All Full-Time Employees in Active Employment in the United States working a minimum of 30 hours per week.

**Paying for Coverage**

**Method of Premium Payment:** Remitted by Policyholder  
You may be required to contribute, either in whole or in part, to the cost of your coverage. This is subject to the terms established by the Policyholder.

**Schedule of Benefits**

The benefits an Insured may receive for a Payable Claim are listed in the Schedule of Benefits, subject to all other terms and provisions of this Certificate.

## Group Vision Insurance Schedule of Benefits

The following Schedule of Benefits outline the Covered Services and Materials under your plan.

You are responsible for paying any applicable Co-Pay, per Insured. You are also responsible for paying any amount in excess of the Allowance, if applicable.

Please refer to the Limitations provision located in the Vision Details section of your Certificate for specific Limitations pertinent to your Plan.

BENEFIT FREQUENCY	
Vision Exam	Once every 12 Months
Eyeglass Lenses	Once every 12 Months
Frames	Once every 24 Months
Contact Lenses	Once every 12 Months
Supplemental Benefits	Once every 12 Months

IN-NETWORK PROVIDER		
Covered Services and Materials	Co-Pay	Benefit after Co-Pay
<b>Eye Exam</b>		
By Ophthalmologist or Optometrist	\$10	Covered in Full
<b>Materials - Eyeglass Lenses</b>		
Single Vision Eyeglass Lenses	\$10	Covered in Full
Bifocal Eyeglass Lenses	\$10	Covered in Full
Trifocal Eyeglass Lenses	\$10	Covered in Full
Standard Progressive Eyeglass Lenses	\$75	Covered in Full
Premium Progressive Lenses Tier 1	\$95	Covered in Full
Premium Progressive Lenses Tier 2	\$105	Covered in Full
Premium Progressive Lenses Tier 3	\$120	Covered in Full
Premium Progressive Lenses Tier 4	\$75	\$120 Allowance
Lenticular Eyeglass Lenses	\$10	Covered in Full
<b>Materials - Frames</b>		
Eyeglass Frames	\$0	\$150 Allowance
<b>Materials - Contact Lenses</b>		
Contact Lenses - Elective	\$0	\$150 Allowance
Contact Lenses - Non-Elective	\$0	Covered in Full

OUT-OF-NETWORK PROVIDERS	
Covered Services and Materials	Benefit
<b>Eye Exam</b>	
By Ophthalmologist or Optometrist	\$40 Allowance
<b>Materials - Eyeglass Lenses</b>	
Single Vision Eyeglass Lenses	\$30 Allowance
Bifocal Eyeglass Lenses	\$50 Allowance
Trifocal Eyeglass Lenses	\$70 Allowance
Standard Progressive Eyeglass Lenses	\$50 Allowance
Premium Progressive Lenses Tier 1	\$50 Allowance
Premium Progressive Lenses Tier 2	\$50 Allowance
Premium Progressive Lenses Tier 3	\$50 Allowance
Premium Progressive Lenses Tier 4	\$50 Allowance
Lenticular Eyeglass Lenses	\$70 Allowance
<b>Materials - Frames</b>	
Eyeglass Frames	\$105 Allowance
<b>Materials - Contact Lenses</b>	
Contact Lenses - Elective	\$150 Allowance
Contact Lenses - Non-Elective	\$210 Allowance

SUPPLEMENTAL BENEFITS IN-NETWORK PROVIDERS		
Covered Materials	Co-Pay	Benefit after Co-Pay
Polycarbonate upgrade for Children < 19	\$0	Covered in Full

SUPPLEMENTAL BENEFITS OUT-OF-NETWORK PROVIDERS	
Covered Services and Materials	Benefit
Polycarbonate upgrade for Children < 19	\$32

The information in this section provides details about the benefits that may be payable to you and any applicable Exclusions and Limitations.

**Vision Benefits**

This Certificate provides coverage for Eye Exams and Vision Materials. The Covered Services and Materials, and Frequencies are shown in the Schedule of Benefits. Some of the language we use in this Certificate contains technical vision terms that will be familiar to your provider.

**Eye Exams***Benefit Description*

Eye Exams are shown in the Schedule of Benefits. In order for an Eye Exam to be covered, the exam must be:

- Within the allowable Frequency shown in the Schedule of Benefits; and
- By an Ophthalmologist or Optometrist, regardless of whether such provider is an In-Network or Out-of-Network Provider.

In no event will coverage exceed the lesser of:

- the actual cost incurred; or
- the Benefits and Allowances shown in the Schedule of Benefits.

An Eye Exam is an examination of principal vision functions which includes, but is not limited to:

- case history;
- examination for pathology or anomalies;
- job visual analysis;
- refraction;
- visual field testing; or
- tonometry, if indicated.

The exam must be consistent with the community standards, rules and regulations of the jurisdiction in which the provider's practice is located.

**Covered Materials**

Covered Materials are shown in the Schedule of Benefits. In order to be a Covered Material, the Materials must be furnished to an Insured:

- Within the allowable Frequency shown in the Schedule of Benefits; and
- By an Ophthalmologist, Optometrist or Optician, regardless of whether such provider is an In-Network or Out-of-Network Provider.

In no event will coverage exceed the lesser of:

- the actual cost incurred of the Covered Materials; or
- the Benefits and Allowances shown in the Schedule of Benefits.

**In-Network Benefits**

When you enroll for coverage, a Provider Directory will be made available to you. The Provider Directory is made up of In-Network Providers who are available to you. You may select any of the In-Network Providers and change providers at any time without notice. A provider's status may occasionally change. You may contact us to verify a provider's participation status in the network, by calling customer service at (866) 800-5457 or online at [www.eyemedvisioncare.com/unum](http://www.eyemedvisioncare.com/unum).

When benefits are payable for Covered Services or Materials received from an In-Network Provider, we will pay the In-Network Provider directly, based on the In-Network Benefits shown in the Schedule of Benefits. The Insured will be responsible for any required Co-Pay and any cost that exceeds the Allowance. The Co-Pay and the Allowance are both shown in the Schedule of Benefits

You will generally incur lower cost by using an In-Network Provider.

When benefits are payable for Covered Services or Materials received from an In-Network Provider and are combined with a discount, or other in-store offer, the provider may require that you pay in full and submit your receipt for the Out-of-Network reimbursement.



**Out-of-Network  
Benefits**

In addition to In-Network Providers, you also have access to Out-of-Network Providers. If you select an Out-of-Network Provider, you will pay more than if you select an In-Network Provider. An Out-of-Network Provider may expect payment in full for the Covered Services or Materials purchased at the time they are provided. Please refer to the Filing a Claim provision for further information on submitting a claim.

When benefits are payable for Covered Services or Materials received from an Out-of-Network Provider, we will reimburse you up to the amount of out-of-network benefits as shown in the Schedule of Benefits.

**Exclusions**

We will not pay benefits for the following, unless otherwise specifically listed as a Covered Service or Material in the Schedule of Benefits:

- Replacement frames and/or lenses, except at normal intervals when Covered Services are otherwise available;
- Plano or non-prescription lenses or sunglasses;
- Orthoptics, vision training and any associated supplemental testing;
- Low (subnormal) vision aids or aniseikonic lenses;
- Medical and surgical treatment of the eyes;
- Experimental or non-conventional treatment or device;
- Any eye examination or corrective eyewear required by an Employer as a condition of employment;
- Services for which benefits are paid by Worker's Compensation;
- Two pairs of glasses, in lieu of bifocals, trifocals, or progressives;
- Additional cost for contact lenses over the Benefit Payable;
- Additional cost for a frame over the Benefit Payable.

We will also not pay any claims incurred after:

- the Policy ends; or
- the Insured's coverage under the Policy ends, except as stated in the Policy.

**Limitations**

The Contact Lenses Benefit is paid in lieu of Eyeglass Lenses. An Insured is eligible to receive benefits under the Eyeglass Lenses Benefit only after the Contact Lenses benefit Frequency has ended.

The Eyeglass Lenses Benefit is paid in lieu of the Contact Lenses Benefit. An Insured is eligible to receive benefits under the Contact Lenses Benefit only after the Eyeglass Lenses benefit Frequency has ended.

<b>Waiting Period</b>	Immediately following 90 days of continuous Active Employment.
<b>Coverage Eligibility Date</b>	<p><i>For you</i> If you are in an Eligible Group, you are eligible for coverage on the later of:</p> <ul style="list-style-type: none"> <li>- the Policy Effective Date; or</li> <li>- the day after any applicable Waiting Period has been satisfied.</li> </ul> <p><i>For your Spouse</i> If you elect coverage for yourself, your Spouse is eligible for coverage on the later of:</p> <ul style="list-style-type: none"> <li>- the date you are eligible for coverage; or</li> <li>- the date you first acquire a Spouse.</li> </ul> <p><i>For your Children</i> If you elect coverage for yourself, your Children are eligible for coverage on the later of:</p> <ul style="list-style-type: none"> <li>- the date you are eligible for coverage; or</li> <li>- the date you first acquire the Child.</li> </ul> <p>Your newborn or newly adopted Children will automatically be covered for 31 days from their Coverage Eligibility Date if you are insured.</p> <p>If you wish to continue Child coverage, you must notify us on or before the end of the 31 day period and pay any additional premium.</p>
<b>Enrolling for Coverage</b>	<p><b>Initial Enrollment</b> You may apply for any coverage available for you, your Spouse, and Children within 31 days of an Insured's Coverage Eligibility Date.</p> <p>You may also apply for any coverage available for you, your Spouse, and Children during any scheduled Enrollment Period, or within 31 days of a Qualifying Life Event. Annual enrollment is a period of time specified by the Policyholder and agreed upon by us.</p>
<b>Coverage Effective Date for Changes in Coverage</b>	<p><i>Changes in Coverage Requested by You</i> Changes in coverage for an Insured will begin immediately following the later of:</p> <ul style="list-style-type: none"> <li>- immediately following the date your applicable Enrollment Period ends;</li> <li>- immediately following the date you apply for the change in coverage due to a Qualifying Life Event, if it's within 31 days of the Qualifying Life Event.</li> </ul> <p>Any cancellation in coverage for an Insured will take effect on the first day of the month following the later of:</p> <ul style="list-style-type: none"> <li>- the date the cancellation in coverage is made; or</li> <li>- the date agreed upon by us and your Employer.</li> </ul> <p>Any change or cancellation in coverage will not affect a Payable Claim that occurs prior to the change or cancellation.</p>
<b>Coverage Effective Date if you are not in Active Employment</b>	<p>You must be in Active Employment in order for coverage to become effective in accordance with the Coverage Effective Date provision.</p> <p>If you are not in Active Employment due to an Injury, Sickness, or Leave of Absence on the date coverage would become effective, the Insured's Coverage Effective Date will be the date you return to Active Employment.</p> <p>Coverage Effective Date for Initial Enrollment, Late Enrollment, and Changes in Coverage are subject to this provision.</p>

**Continuation of  
your Coverage  
During Extended  
Absences***Leave of Absence, other than a Family and Medical Leave of Absence or Leave of Absence due to Military Service*

You will be covered for 1 year from the date your absence begins, provided premium is paid.

*Family and Medical Leave of Absence*

We will continue coverage in accordance with your Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and your Employer approved your leave in Writing. You will be covered up to the end of the latest of:

- the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments;
- the leave period required by applicable state law; or
- the leave period provided to you for an Injury or Sickness, provided premium is paid and your Employer has approved your leave in Writing.

If your Employer's Human Resource policy doesn't provide for continuation of your coverage during a Family and Medical Leave of Absence, coverage will be reinstated when you return to Active Employment.

We will not apply a new Waiting Period.

*Leave of Absence due to Military Service*

You will be covered for 1 year from the date your absence begins, provided premium is paid.

If you have not returned to work after the allotted time for continuation of coverage, your coverage will be suspended and reinstated in accordance with the requirements of the federal Uniformed Services Employment and Reemployment Rights Act (USERRA).

*Injury or Sickness*

You will be covered for up to 1 year from the date your absence due to an Injury or Sickness begins, provided premium is paid.

**End of Coverage***For You*

Your coverage under this Certificate ends on the earliest of:

- the date the Policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage During Absences provision.

We will provide coverage for a Payable Claim that occurs while you are covered under this Certificate.

*For your Spouse*

If, while your coverage is in force, you choose to cancel your Spouse's coverage under this Certificate, your Spouse's coverage will end on the date you provide notification to your Employer.

Otherwise, your Spouse's coverage will end on the earliest of:

- the date your coverage under this Certificate ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

## **End of Coverage**

We will provide coverage for a Payable Claim that occurs while your Spouse is covered under this Certificate.

### *For your Children*

If, while your coverage is in force, you choose to cancel your Children's coverage under this Certificate, your Children's coverage will end on the date you provide notification to your Employer.

Otherwise, your Children's coverage will end on the earliest of:

- the date your coverage under this Certificate ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

We will provide coverage for a Payable Claim that occurs while your Children are covered under this Certificate.

**Filing a Claim**

We encourage early notification of a claim for benefits under this Certificate so that a claim decision can be made in a timely manner. If there are any questions on how to file a claim, please contact the Administrator or your Employer.

***In-Network Claims***

When an Insured receives services from an In-Network Provider, the provider will handle all claims and administrative services for you. In-Network Providers submit charges directly to the Administrator.

***Out-of-Network Claims***

In order to pay benefits for Covered Services or Materials provided by an Out-of-Network Provider, we must receive Written proof of loss. The claim must identify the Insured, the name of the Policyholder and the Group Policy Number. Claim forms are available from the Administrator or you may submit itemized receipts from the provider for services.

***Step 1 - Starting a Claim***

Notice of a claim may be provided in Writing or by contacting the Administrator directly at (866) 800-5457. Notice of a claim should be provided within 30 days from the date of the Covered Loss, or as soon as reasonably possible.

***Step 2 - Claim Forms***

After receiving notice of a claim, we will send a claim form to you, the provider, or your authorized representative within 15 days from the date we receive the notice of a claim. Claim forms may also be available from your Employer or from the Administrator online at: [https://www.eyemedvisioncare.com/oon/EMVC\\_OON\\_Form.pdf](https://www.eyemedvisioncare.com/oon/EMVC_OON_Form.pdf).

If you or your authorized representative do not receive a claim form from the Administrator within 15 days after we receive notice of a claim, a Written statement from you or your authorized representative as to the nature and extent of the Covered Loss will be deemed Proof of Loss, if sent to the Administrator within the time limit stated in the Proof of Loss section below.

Completed claim forms may be sent to the Administrator by mail:

Mailing Address: First American Administrators, Inc., Attn: OON Claims, P.O. Box 8504, Mason, OH 45040-7111

***Step 3 - Proof of Loss***

Proof of Loss must be sent to the Administrator no later than 90 days after the date of Covered Loss. If it is not reasonably possible to provide Proof of Loss within this time period, it will not affect a Payable Claim if it is provided within one year, unless the Insured lacks the legal capacity to do so.

In no event can Proof of Loss be submitted after the expiration of the time limit for commencing Legal Action as stated in this Certificate, even if the failure to provide Proof of Loss is due to a lack of legal capacity or if state law provides an exception to the one-year time period.

Proof of Loss, provided at your or your authorized representative's expense, must establish the nature and extent of the Covered Loss and should include but not be limited to the following:

- the extent of the Covered Loss;
- the date of Covered Loss;
- the name and address of any provider where treatment was received.

If the Proof of Loss is not complete, we will request additional information.

**Physical  
Examinations  
and Autopsy**

The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

### **Claim Procedures**

After the Insured has satisfied the requirements under Filing a Claim, we will process and evaluate the information to determine if a claim is payable. We will notify the Insured of a claim decision and issue payment for a Payable Claim immediately within 30 days. Benefits will be paid in accordance with the Payment of Benefits provision.

If we determine additional time is needed to review a claim, we may extend this time period by 30 days. We will notify the Insured of the circumstances requiring a review extension and when we anticipate making a claim decision.

If a claim for benefits under this Certificate is wholly or partially denied, we will provide notice of our decision in Writing. The notice of denial will state the specific reason for the denial of benefits.

### **Payment of Benefits**

Benefits for which we are liable will be paid after we complete the Claims Procedures. All benefits will be paid to you, unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits.

If there are legal impediments to Payment of Benefits under this Certificate which depend on the actions of parties other than us, we may hold further benefits due until such impediments are resolved and sufficient Proof of Loss of the same is provided to us.

In the event of your death, any unpaid benefits will be paid to your estate. If benefits are payable to your estate, we can pay benefits up to \$1,000 to someone related to you by blood or marriage whom we consider entitled to the benefits. Any payment made by us in good faith pursuant to this provision will fully release us to the extent of such payment.

### **Payment of Interest**

Any benefit payment issued after 30 days from the date we receive satisfactory proof will accrue simple interest on the net benefit amount to be paid in accordance with the state requirements beginning on the 31st day and ending on the date we make the payment.

### **Change of Beneficiary**

The right to change a beneficiary is reserved to you and the consent of the beneficiary or beneficiaries shall not be requisite to assignment of the Policy and this certificate or to change of beneficiary or beneficiaries, or to any changes in the Policy or this certificate. A change of beneficiary will not have a bearing on any payment we make before we receive it.

### **Payments to a Minor or Incompetent Insured**

If an Insured is a minor or is incompetent, we can pay up to \$1,000 to the person or institution that appears to have assumed the custody and main support of the Insured or the minor unless or until that Insured, or minor's appointed legal representative makes a formal claim. If we pay benefits to such person or institution, we will not have to pay those benefits again.

### **Overpayment of Claims**

We have the right to recover any overpayments due to:

- fraud;
- Misstatement of Information; or
- any error we make in processing a claim.

We must be reimbursed in full. If it is not possible for you to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments. This applies to payments made to you, your Spouse and your Children or to the provider of the Covered Services or Materials.

We will not recover more money than the amount we paid you.

### **Underpayment of Claims**

We have the responsibility to make additional payments if any underpayments have been made. Any underpayments will be paid in accordance with the Payment of Benefits provision.

### **Grievance Procedures**

*Complaints and Grievances  
Internal Review*

## Claim Provisions

You shall report any complaints and/or grievances to us in Writing at Quality Assurance Department, 4000 Luxottica Place, Mason, OH 45040, by fax at (513) 492-3259, by e-mail at [eyemedqa@eyemed.com](mailto:eyemedqa@eyemed.com), or by phone at (877) 226-1115. Complaints and grievances may be submitted to us verbally or in Writing. You may submit Written comments or supporting documentation concerning your complaint or grievance to assist in our review. We will address the complaint or grievance within 30 days after receipt or, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than 120 days after our receipt of the complaint or grievance.

Copies of all grievances and responses are available for inspection by the Director of the Michigan Department of Insurance and Financial Services for a period of two years following the year the grievance was filed.

### *Grievances*

We will address the complaint or grievance within 60 calendar days after receipt. This timeframe may be extended at your request, for up to 10 business days for us to make a decision if we have not received requested information from your provider.

### *Expedited Grievances*

This grievance procedure will apply if a grievance is submitted and a physician, orally or in writing, substantiates that applying the timeframes for resolving grievances would seriously jeopardize the life or health of the insured or enrollee or would jeopardize the insured's or enrollee's ability to regain maximum function. In such a case, a determination on the expedited grievance will be made within 72 hours of receipt. Within 10 days after receipt of the grievance determination, you may request a review of the matter by a director or independent review organization.

### *Claim Denial*

If we deny all or any part of your claim, you can access the claim status detail on [www.eyemedvisioncare.com/unum](http://www.eyemedvisioncare.com/unum), you have the right to receive a Written notice of denial setting forth:

- the specific reasons for the denial;
- the specific Policy provisions on which the denial is based;
- a description of the appeal procedures and time limits;
- your right to bring a civil action under ERISA, §502(a) following an adverse determination on review; and

Upon receipt of a claim denial you have the right, upon request and free of charge, to receive:

- copies of all documents, records, and other information relevant to your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary.

### *Claim Denial Appeal*

If, under the terms of the Policy, a claim is denied in whole or in part, a request may be submitted to us by you, or by your authorized representative, for a full review of the denial. You may designate any person, including your provider, as your authorized representative. References in this section to "you" include your authorized representative, where applicable.

The request must be made within 180 days following your receipt of the Written notification of adverse benefits determination and should contain sufficient information to identify the person for whom the claim was denied, including:

- your or your Spouse's or Children's name;
- your or your Spouse's or Children's identification number and date of birth;
- the provider of services; and
- the claim number.



## Claim Provisions

You may request, free of charge, any documents held by us regarding the denial of your claim. You may also submit Written comments or supporting documentation concerning the claim to assist in our review. Our response to your appeal, including specific reasons for the decision and reference to the specific plan provision on which the benefit determination is based, shall be provided and communicated to you as follows:

Within 60 days after receipt of a request for an appeal from you, unless, due to special circumstances, we need an extension of time to process your appeal. In the event that we do request an extension of time, notice will be provided to you prior to the expiration of the initial 60 day period, and the extension will not exceed a period of 60 days from the end of the initial 60 day time period.

### *Other Remedies*

When you have completed the appeals process described above, additional voluntary alternative dispute resolution options may be available, including mediation. One way to find out what may be available is to contact the U.S. Department of Labor and your State insurance regulatory agency.

Additionally, under the provisions of ERISA (Section 502(a)) 29 U.S.C. 1132(a), you have the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole, and you disagree with the outcome.

### *External Review*

Generally, you must exhaust our Internal Review procedures before you can request an external review. Exceptions might apply.

You have 127 days from the date an adverse determination is received to request an external review with the Michigan Department of Insurance and Financial Services (DIFS).

If you need the assistance of the governmental agency that regulates insurance, you may contact the Department of Insurance by mail, telephone or email.

#### **Regular Mail:**

DIFS Office of General Counsel- Appeals Section P.O. Box 30220 Lansing, MI 48909

#### **Overnight Mail:**

530 W. Allegan Street, 7th Floor Lansing, MI 48933

Telephone: (877) 999-6442

E-mail: [DIFS-HealthAppeal@michigan.gov](mailto:DIFS-HealthAppeal@michigan.gov)

Online Portal: [difs.state.mi.us/Complaints/ExternalReview.aspx](https://difs.state.mi.us/Complaints/ExternalReview.aspx)

## Legal Actions

The time limit on Legal Actions for a Covered Loss is subject to applicable law in the state where the Policy was issued.

If you or your authorized representative disagree with our decision, you or your authorized representative can start Legal Action regarding your claim 60 days after Proof of Loss has been given to us and up to three years from the latest of when:

- original Proof of Loss was first required to have been given to us;
- your claim was denied; or
- your benefits were terminated,

unless otherwise provided under federal law.

<b>When Days Begin and End</b>	For the purpose of all dates under this Certificate of Coverage, all days begin at 12:01 a.m. and end at 12:00 midnight.
<b>Certificate of Coverage Contents</b>	<p>Coverage for an Insured is provided under this Certificate of Coverage which is a part of the Policy issued to the Policyholder. The Policy consists of:</p> <ul style="list-style-type: none"><li>- all Policy provisions, and any riders, amendments and endorsements, and other attachments to the Policy;</li><li>- this Certificate of Coverage, and any riders, amendments and endorsements, and other attachments to this Certificate of Coverage;</li><li>- the Policyholder's application for group insurance; and</li><li>- Employee's signed applications, if applicable.</li></ul>
<b>Your Certificate of Coverage</b>	<p>We will provide the Employer with a Certificate of Coverage for distribution to each Insured Employee. Your Certificate describes:</p> <ul style="list-style-type: none"><li>- the coverage to which an Insured may be entitled;</li><li>- to whom we will make a payment; and</li><li>- the limitations, exclusions, and requirements that apply to an Insured's coverage.</li></ul> <p>If any of the terms and provisions of this Certificate are different than in the Policy, the Policy will govern.</p>
<b>Cancellation or Modification to the Policy and this Certificate of Coverage</b>	<p>The Policy and this Certificate of Coverage may be cancelled or modified by the Employer at any time without the Insured's consent. Any cancellation or modification to the Policy or Certificate requested by the Employer will take effect on the date agreed upon by us and the Employer.</p> <p>All Policy and Certificate modifications will take effect according to the Coverage Effective Date for Changes in Coverage provision.</p>
<b>Representation in Applications</b>	Any statements made by you will be considered a representation and not a warranty. We will not use such statements to avoid insurance, reduce benefits, or deny a claim unless it is included in an application signed by you, and a copy of the signed application has been provided to you.
<b>Assignment</b>	<p>An Assignment transfers all or part of your legal title and rights under the Policy and this Certificate to someone else, known as an "assignee." We will recognize your assignee(s) as owners of the rights you transferred under the Policy and this Certificate if:</p> <ul style="list-style-type: none"><li>- the Written form has been signed by you and the assignee and the form is acceptable to us; and</li><li>- a signed or certified copy of the Written Assignment has been filed with us.</li></ul> <p>An Assignment will take effect on the date notice of the Assignment is signed by you. If we have taken any action or made any payment before we receive notice of the Assignment, that Assignment will not go into effect for those actions taken or payments made. An Assignment does not change an Insured's coverage.</p> <p>We are not responsible for the validity of any Assignment. We advise you to verify your Assignment is legal in your state and that it accomplishes the goals you intend.</p>
<b>Contestability</b>	We can take legal or other action using statements made in signed applications for coverage only when a Covered Loss occurs during the first two years after an Insured's Coverage Effective Date. However, in the event of Fraud, we can take Legal Action at any time as permitted by applicable law.
<b>Misstatement of Information</b>	<p>If you or your Employer provide us information about an Insured that is incorrect, we will:</p> <ul style="list-style-type: none"><li>- use the facts to decide whether the Insured has coverage under this Certificate and the Policy and in what amounts; and</li><li>- if necessary, make the applicable premium adjustments.</li></ul>
<b>Fraud</b>	We want to make sure you and your Employer do not incur additional insurance costs as the result of the undermining effects of insurance fraud. We promise to focus on all means

## General Provisions

necessary to support fraud detection, investigation, and prosecution.

It is a crime if anyone knowingly, and with intent to injure, defrauds, or deceives us. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

These actions will result in denial of a claim, and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

### Agency

For purposes of the Policy, your Employer acts on their own behalf or as your agent. Under no circumstances will your Employer be deemed our agent.

### Communicating with you or your Employer

We may provide notices, information, and other communications to you or your Employer in Written form.

To protect our customers, we will abide by all applicable privacy laws and regulations.

<b>Active Employment</b>	<p>You are working for your Employer for earnings that are paid regularly, and you are performing the usual and customary duties of your job. You must be regularly scheduled to work at least the minimum number of hours as determined by your Eligible Group Employer.</p> <p>Your work site must be:</p> <ul style="list-style-type: none"> <li>- your Employer's usual place of business in the United States;</li> <li>- an alternative work site in the United States at the direction of your Employer; or</li> <li>- a location in the United States to which your job requires you to travel.</li> </ul> <p>Normal vacation, holidays, or temporary business closures are considered Active Employment provided you are in Active Employment on the last scheduled work day preceding such time off.</p> <p>For purposes of this Certificate, temporary business closures that meet the Glossary definition of Active Employment include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- inclement weather;</li> <li>- power outage; and</li> <li>- public health agency orders.</li> </ul> <p>Temporary and seasonal workers are excluded from coverage.</p>
<b>Administrator</b>	<p>The entity which provides complete service to review and pay claims under the Policy as agreed to in a contract with us.</p>
<b>Allowance</b>	<p>The maximum amount we will pay for Covered Services or Materials as shown in the Schedule of Benefits.</p>
<b>Certificate of Coverage or Certificate</b>	<p>The document issued to the Employee describing an Insured's benefits and rights under the Policy, including any riders, amendments and endorsements, and other attachments to this Certificate and the Policy.</p>
<b>Children</b>	<p>Any child from live birth to the end of the year in which they reach age 26 who is:</p> <ul style="list-style-type: none"> <li>- your own natural offspring;</li> <li>- your Spouse's child;</li> <li>- your lawfully adopted child as of the earliest of the date: <ul style="list-style-type: none"> <li>- the child is placed in your home or in a medical facility;</li> <li>- a petition is filed for you to adopt the child; or</li> <li>- an adoption agreement signed by you that includes your binding obligation to assume financial responsibility for the child;</li> </ul> </li> <li>- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;</li> <li>- grandchildren, nieces, and nephews living with you in a regular parent child relationship that are dependent on you for primary financial support; or</li> <li>- any other child residing with you through legal mandate that is dependent on you for financial support.</li> </ul> <p>Coverage for your Child may be continued past the end of the year in which they reach age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.</p> <p>You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.</p> <p>Your Children may not be Insured as both a Child and an Employee.</p> <p>Your Children may not be Insured by more than one Employee.</p>

<b>Co-Pay</b>	The amount an Insured must pay to a provider before benefits are payable for Covered Services or Materials. The Co-Pay is paid directly to the provider at the time services are rendered. Co-Pay amounts are listed in the Schedule of Benefits.
<b>Contact Lenses, Elective</b>	Contact lenses an Insured chooses to wear instead of eyeglasses for reasons of comfort or appearance.
<b>Contact Lenses, Non-Elective</b>	<p>Contact lenses that are prescribed solely for the purpose of correcting one of the following medical conditions. These conditions prevent the Insured from achieving a specified level of visual acuity (performance) through the wearing of conventional eyeglasses.</p> <ul style="list-style-type: none"> <li>- High Ametropia exceeding -10D or +10D in meridian spectacle Rx powers;</li> <li>- Anisometropia of 3D in meridian spectacle Rx powers;</li> <li>- Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses;</li> <li>- Vision improvement for members whose vision can be corrected by 2 lines on the visual acuity chart when compared to the best corrected standard spectacle lenses.</li> </ul> <p>Medically necessary contact lenses are available in lieu of ophthalmic lenses and are subject to plan copayments and frequency limits. The provider determines the member's qualifying criteria at examination and evaluation.</p>
<b>Contributory Coverage</b>	Any amount of coverage for which you pay all or part of the premium. The maximum amount that you may be required to contribute to the cost of your coverage shall not exceed the premium charged for the amounts of your coverage.
<b>Covered in Full</b>	The In-Network Provider has agreed to accept a negotiated amount for the Covered Services or Materials as payment in full. The Insured is not responsible for any charges for the Covered Services or Materials other than the applicable Co-Pay.
<b>Covered Services or Materials</b>	The Vision Exam services and Materials that qualify for benefits under the Policy. Covered Services or Materials are shown in the Schedule of Benefits.
<b>Covered Loss</b>	Benefits will be paid only for losses identified in the Schedule of Benefits.
<b>Employee</b>	A person, also referred to as "you," who is in Active Employment in the United States with the Employer.
<b>Employer</b>	The Policyholder, including all United States divisions, subsidiaries, and affiliated companies of the named Policyholder for whose Employees premium is being paid.
<b>Enrollment Period</b>	A period of time determined by your Employer and us during which you are eligible to enroll for or change your coverage. This period of time may be limited.
<b>Eyeglass Lenses</b>	A standard plastic (CR39) lens, which is optically clear, that will fit an eye glass frame with a lens size less than 61mm in length. Standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, through flat top 28 for glass trifocals, and through flat top 35 for plastic trifocals.
<b>Injury and Sickness</b>	<p>A bodily Injury, illness, infection, disease, or any other abnormal physical condition, which:</p> <ul style="list-style-type: none"> <li>-occurs on or after the initial effective date;</li> <li>-occurs while coverage is in force; and</li> </ul> <p>is not excluded by name or specific description in the Certificate.</p>
<b>Insured</b>	Any person who has coverage under this Certificate.
<b>In-Network Provider</b>	An Ophthalmologist, Optometrist or Optician who has entered into an agreement with the network selected by the plan to provide Covered Services or Materials at an agreed to cost.

<b>Leave of Absence</b>	<p>Temporary absence from Active Employment for a period of time under a leave granted in Writing by your Employer that is in accordance with your Employer's formal leave policies.</p> <p>Normal vacation time, holidays, or temporary business closures are not considered a Leave of Absence.</p>
<b>Ophthalmologist</b>	<p>A person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology.</p> <p>We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as an Ophthalmologist for a claim that you send to us.</p>
<b>Optician</b>	<p>A person or business that grinds and/or dispenses Eyeglass Lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.</p> <p>We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as an Optician for a claim that you send to us.</p>
<b>Optometrist</b>	<p>A person licensed to practice optometry, as defined by the laws of the state in which services are rendered.</p> <p>We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as an Optometrist for a claim that you send to us.</p>
<b>Out-of-Network Provider</b>	<p>An Ophthalmologist, Optometrist or Optician who is not an In-Network Provider. These providers have not entered into an agreement with us to limit their charges. They are not listed in the In-Network Provider Directory.</p>
<b>Payable Claim</b>	<p>A claim for which we are liable for under the terms of this Certificate.</p>
<b>Policy Year</b>	<p>July 1, 2024 to January 1, 2025 and each following January 1 to January 1.</p>
<b>Plano Lens</b>	<p>A lens that has no refractive power.</p>
<b>Policy</b>	<p>The Group Vision Insurance Policy issued to the Policyholder, including this Certificate of Coverage and any riders, amendments and endorsements, and other attachments to this Certificate and the Policy.</p>
<b>Policyholder</b>	<p>The entity to which the Policy is issued.</p>
<b>Provider Directory</b>	<p>A list of In-Network Providers for your plan. You can verify if a provider is an In-Network Provider by calling customer service at (866) 800-5457 or online at <a href="http://www.eyemedvisioncare.com/unum">www.eyemedvisioncare.com/unum</a>.</p>
<b>Qualifying Life Event</b>	<p>An event including, but not limited to:</p> <ul style="list-style-type: none"> <li>- birth, adoption, or addition of a Child;</li> <li>- a change in legal marital status;</li> <li>- a change in employment status; or</li> <li>- death of an Insured.</li> </ul> <p>Qualifying Life Event coverage changes made in accordance with the Start of Coverage provisions must be consistent with the Qualifying Life Event.</p> <p>For further information regarding Qualifying Life Events, please refer to your Employer's Human Resource policy.</p>

<b>Spouse</b>	<p>The person who is your partner through lawful marriage, civil union, registered domestic partnership, unregistered domestic partnership (established by a declaration acceptable to us), or your legally separated Spouse.</p> <p>Your Spouse may not be insured as both a Spouse and an Employee.</p>
<b>Starmount Life Insurance Company</b>	<p>Referred to as "Starmount" and "we," "us," or "our."</p>
<b>Writing or Written</b>	<p>A record on or transmitted by paper, electronic, or telephonic media consistent with applicable law.</p>

# Privacy Notice

This Privacy Notice applies to Unum Group's United States insurance operations and is being provided on behalf of its affiliates listed below ("Unum" "we"), as required by the Gramm-Leach Bliley Act and state insurance laws. This Notice describes how we collect, share, and protect nonpublic personal information (NPI).

## COLLECTING INFORMATION

We collect NPI about our customers to provide them with insurance products and services, perform underwriting, provide stop loss coverage, and administer claims. The types of NPI we collect for these purposes may include telephone number, address, Social Security number, date of birth, occupation, income, and medical history, including treatment. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

## SHARING INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us perform underwriting, provide stop loss coverage, pay claims, detect fraud, and to provide reinsurance or auditing. We may share NPI with medical providers for insurance and treatment purposes and with insurance support organizations. The organizations may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes, with parties for a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

## SAFEGUARDING INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

## ACCESS TO INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing, providing your full name, address, telephone number and policy number, to the address below. We will reply within 30 business days of receipt. If you request, we will send copies of the NPI to you or make available to you at our office. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

## CORRECTION OF INFORMATION

If you believe the NPI we have about you is incorrect, please write to us and include your full name, address, telephone number and policy number if we have issued a policy, and the reason you believe the NPI is inaccurate. We will reply within 30 business days of receipt. If we agree with you, we will correct the NPI and



notify you and insurance support organizations that may have received NPI from us in the preceding 7 years. We will also, if you ask, notify any person who may have received the incorrect NPI from us in the past 2 years.

If we disagree with you, we will tell you we are not going to make the correction and the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct and the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI to be accessible. We will include your statement any time the disputed NPI is reviewed or disclosed. We will also give the statement to insurance support organizations that gave us NPI and to any person designated by you, if we disclosed the disputed NPI to that person in the past two years.

### **COVERAGE DECISIONS**

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI. You may submit a written request for the reason(s) for our decision within 90 business days of our decision. We will reply within 21 business days of receipt with the specific reasons, if not initially furnished, and specific items of information that supported our decision.

### **CONTACTING US**

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: [unum.com/privacy](http://unum.com/privacy) or [coloniallife.com](http://coloniallife.com). You may also write to: Privacy Officer, Unum, 2211 Congress Street, B267, Portland, Maine 04122 or at [Privacy@unum.com](mailto:Privacy@unum.com).

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.

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[unum.com](http://unum.com)

MK-1883 (06-2020)

# Accessibility Services

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## Hearing Impairment

We utilize a TTY line for communication with individuals who are hearing-impaired. Insureds may initiate a call through the TTY by calling a toll-free number or, in the event a call is received from a hearing-impaired individual on our standard Member Services line, the Member Services representative initiates a call to the TTY Service.

## Other Special Needs

Insureds face many special needs, many of which cannot be foreseen and planned for. As we, our clients, and our participating providers identify insureds with special needs, we will make such arrangements as are necessary to provide equal access to administrative and vision/dental care services as are provided to insureds who do not have special needs. Due to varying individual needs, the nature of such arrangements is determined on a case-by-case basis pursuant to the special need identified. Such arrangements may include providing documents in large font format or allowing an insured to receive services from a non-participating provider, as appropriate to the situation and within the benefits provided in the Certificate of Insurance.

## Interpretation & Translation

### Notice Regarding Translator and Interpretation Services

We offer interpreter service for non-English speaking members. Our service interprets over 180 languages and dialects. If you require language assistance, please contact our customer service department at (888) 249-5194 to be connected to an interpreter.

#### Spanish

#### Noticia en Relación de Servicios traductores y Interpretes

Ofrecemos servicios de intérpretes para los miembros que no hablan inglés. Nuestro servicio interpreta más de 180 idiomas y dialectos. Si usted requiere asistencia lingüística, por favor contacte nuestro departamento de servicios de atención al cliente al (888) 249-5194 para ponerse en contacto con un intérprete.

#### Russian

#### Уведомление об услугах устного и письменного перевода

Мы готовы предложить услуги переводчиков участникам, которые не говорят на английском языке. Выполняем переводы с и на более 180 языков и диалектов. Если вам нужна помощь переводчика, свяжитесь с ним, позвонив в наш отдел обслуживания клиентов по номеру: (888) 249-5194.

#### French

#### Avis concernant les traducteurs et les services d'interprétations

Nous proposons des services d'interprétation aux membres ne parlant pas l'anglais. Nous sommes en mesure de traduire dans plus de 180 langues et dialectes. Si vous avez besoin d'une assistance linguistique, veuillez contacter notre service clients au (888) 249-5194 pour être mis en relation avec un interprète.

#### Khmer (Cambodian)

## **ສເຕຊຸຊັຊຸສຂໍຝຶ້ງຮາກຸ່ງສເລີ້ນສເກບກຸບຸບກາສາສເລີ້ນສເນ ສີ່ງກາບກຸບຸບກາສາສເລີ້ນຊຸຮາລໍ່ມາຄໍ່**

ພ ເີ່ງຊຸຮາລໍ່ມາຄໍ່ ພເກບກຸບຸບກາສາສເລີ້ນ ຊຸຮາລໍ່ມາຄໍ່ ເມກບໍ່ເມກຊິກບຸໂລມີສຸນີພາ ກາສາສເລີ້ນສເນ  
ພເກບກຸບຸບກາສາ ສີ່ງກາບກຸບຸບກາສາສເລີ້ນ 180 ກາສາສເລີ້ນ ພເກບກຸບຸບກາສາສເລີ້ນສເນ ກາສາ  
ກຸບຸບກາສາສເລີ້ນສເນ ພເກບກຸບຸບກາສາສເລີ້ນສເນ ພເກບກຸບຸບກາສາສເລີ້ນສເນ (888) 249-5194  
ພເກບກຸບຸບກາສາສເລີ້ນສເນ ພເກບກຸບຸບກາສາສເລີ້ນສເນ

### **Loatian**

#### **ແຈ້ງການກ່ຽວກັບການບໍລິການເປພາສາແລະນັກເປພາສາ**

ພວກເຮົາໃຫ້ບໍລິການເປພາສາສາວັດສະມາຊິກ ທີ່ເວົ້າພາສາອັງກິດໄດ້. ພວກເຮົາໃຫ້ບໍລິການເປພາສາຫຼາຍກວ່າ 180  
ພາສາ ແລະ ພາສາອັງກິດ. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອການເປພາສາ,  
ກະລຸນາຕິດຕໍ່ພະແນກບໍລິການເປພາສາຂອງພວກເຮົາທີ່ໂທລະສັບ (888) 249-5194 ເພື່ອພົວພັນກັບນັກເປພາສາ.

### **Haitian**

#### **Avi Anrapò ak Sèvis Tradiksyon ak Entèpretasyon**

Nou ofri sèvis entèprèt pou manm ki pa pale anglè. Sèvis entèprèt nou an genyen plis pase 180 lang ak  
dyalèk. Si w bezwen asistans nan domèn lang, tanpri kontakte depatman sèvis kliyan nou an nan (888) 249-  
5194 pou yo konekte w ak yon entèprèt.

### **Arabic**

نحن نقدم خدمة الترجمة الشفوية للأعضاء غير الناطقين باللغة الإنجليزية. تتوفر خدمتنا بأكثر من 180 لغة ولهجة. إذا كنت بحاجة إلى المساعدة  
اللغوية، يرجى الاتصال بقسم خدمة العملاء لدينا على الرقم 888 (249 - 5194) (لن يتم توصيلك بمترجم شفوي).

### **Greek**

#### **Ανακοίνωση σχετικά με τις υπηρεσίες μετάφρασης και διερμηνείας**

Προσφέρουμε υπηρεσίες διερμηνείας στα μέλη μας που δεν μιλούν την αγγλική γλώσσα. Η υπηρεσία μας  
αναλαμβάνει τη διερμηνεία για πάνω από 180 γλώσσες και διαλέκτους. Αν χρειάζεστε γλωσσική βοήθεια,  
παρακαλούμε να επικοινωνήσετε με το τμήμα εξυπηρέτησης πελατών της εταιρείας μας στον αριθμό (888)  
249-5194 και να ζητήσετε να συνδεθείτε με έναν διερμηνέα.

### **Italian**

#### **Nota relative ai servizi di traduzione e interpretariato**

Offriamo servizi di interpretariato per membri non di lingua inglese. Il nostri interpreti sono in grado di lavorare  
con più di 180 lingue e dialetti. Se avete bisogno dell'assistenza linguistica, contattate il nostro reparto di  
assistenza clienti al numero (888) 249-5194 per essere inoltrati ad un interprete.

### **Portuguese**

#### **Aviso relacionado aos serviços de tradutor e intérprete**

Oferecemos serviço de intérprete para membros que não falam Inglês. O nosso serviço interpreta mais de 180  
idiomas e dialetos. Se você precisar de assistência linguística, contate o nosso departamento de atendimento  
ao cliente no (888) 249-5194 para ser conectado a um intérprete.

### **Chinese**

关于提供译员和口译服务的通知

我们向非英语会员提供口译服务。该项服务涵盖 180 种语言和方言的口译。如果您需要语言方面的帮助，请拨打 (888) 249-5194 联系我们的客服部门，以与一位口译员进行连线通话

### Gujarati

#### ભાષાંતર અને દુભાષણની સેવા સાંબાંધી સૂચના

અંગ્રેજી ના જાણતા હોય તેવા સભ્યો માટે અમે દુભાષણની સેવા આપીએ છીએ. અમે 180 ભાષાઓ અને બોલીઓમાં દુભાષણની સેવા આપીએ છીએ. જો આપને ભાષાસાંબાંધી મદદની જરૂર હોય તો, કૃપા કરી દુભાષણ સાથે વાત કરવા અમારી ગ્રાહક સેવા ષવભાગ (888) 249-5194 સાંપકક કરો.

### Vietnamese

#### Thông báo về Dịch vụ Thông dịch và Biên dịch

Chúng tôi cung cấp dịch vụ thông dịch cho các thành viên không nói tiếng Anh. Dịch vụ của chúng tôi thông dịch hơn 180 ngôn ngữ và thổ ngữ. Nếu quý vị cần hỗ trợ về ngôn ngữ, vui lòng liên hệ với bộ phận dịch vụ khách hàng của chúng tôi theo số (888) 249-5194 để được kết nối với một thông dịch viên.

### Haitian Creole

#### Avi Anrapò Sèvis Tradiktè ak Entèpretasyon

Nou ofri sèvis entèprèt pou manb ki pa pale anglè. Sèvis nou an ofri plis pase 180 lang ak dyalèk. Si w bezwen asistans lang, tanpri kontakte depatman sèvis kliyantèl nou an nan (888) 249-5194 pou w ka konekte ak yon entèprèt.

### Hindi

#### अनुवाद तथा दुभाषया सेवाओं के संबंध में सूचना

हम गैर-अंग्रेज़ी भाषी सदस्यों के लिए दुभाषया सेवा पेश करते हैं। हम 180 से अधिक भाषाओं व बोलियों में दुभाषया सेवा प्रदान करते हैं। यदि आपको भाषा संबंधी सहायता की जरूरत हो तो ककसी दुभाषये से जुडने के लिए कृपया हमारे ग्राहक सेवा षवभाग से (888) 249-5194 पर संपकक करें।

### Mon-Khmer

#### ដំណឹងសុគីអំពីសស្តាកម្មបកប្រែភាសាសុសស្ត និងបកប្រែភាសាផ្ទាល់មាត់

យយើងឧញ្ញមានផ្តល់យវាកម្មបកប្រែភាសាដល់មោជិកទុំងអំបុសលមិននិយាយភាសាអង់យលេ ។  
យវាកម្មបកប្រែភាសាយយើងឧញ្ញ មានលបដណ្តប់យរើសជាង 180 ភាសាទូយ្វៅ និងភាសានិយាយតាមតុំបន់ ។ យបើយ្វោកអនករត្រូវការផ្តន្ទយបុផ្តនកបកប្រែភាសា  
រូមុទក់ទងបុផ្តនកបយរមើអតិថិជនរបយយើងឧញ្ញតាមទូរ័ព្ទទយលេខ (888) 249-5194  
យដើម្បីបីភាបយ្វោកាន់អនកបកប្រែភាសា ។

### Korean

#### 번역 및 통역 서비스 안내

본사는 영어를 모국어로 하지 않는 회원님들께 통역 서비스를 제공합니다. 180개 이상의 언어 및 방언에 대한 통역 서비스를 이용하실 수 있습니다. 언어 지원이 필요하시다면, 고객 서비스 (888) 249-5194로 연락하시면 해당 통역사에게 연결해드립니다.

**Polish**  
**Informacja o usługach tłumaczeń pisemnych i ustnych**

Członkom nieznającym języka angielskiego oferujemy usługę tłumacza ustnego. Tłumaczenia ustne są dostępne w ponad 180 językach i dialektach. Jeśli potrzebujesz pomocy językowej, skontaktuj się z naszym działem obsługi klienta pod numerem (888) 249-5194, aby połączyć się z tłumaczem ustnym.