# *Group Vision Care Plan*

**Group Name:** **LOYOLA UNIVERSITY NEW ORLEANS**
**Group Number:** **12229063**
**Effective Date:** **JANUARY 1, 2008**

## EVIDENCE OF COVERAGE

Provided by:

**VISION SERVICE PLAN INSURANCE COMPANY**
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

To be filled in by employer in the event this document is used to develop a Summary Plan Description:

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| NAME OF EMPLOYER:<br>PRINCIPAL ADDRESS: | Loyola University New Orleans<br>6363 St. Charles Avenue<br>New Orleans, LA 70118<br>(504) 864-7027 |
| NAME OF PLAN: | Loyola University Employee Benefit Plan |
| EMPLOYER I.D.#: | 74-0408946 |
| PLAN #: | 502 |
| PLAN YEAR: | January 1 – December 31 |
| PLAN SPONSOR AND<br>ADMINISTRATOR:<br>ADDRESS: | <br>Loyola University New Orleans<br>6363 St. Charles Avenue<br>New Orleans, LA 70118<br>(504) 864-7027 |
| AGENT FOR SERVICE OF<br>LEGAL PROCESS: | Plan Administrator |
| TYPE OF ADMINISTRATION: | Insurer |
| BENEFITS PROVIDED BY<br>AND DISBURSEMENTS<br>FROM THE PLAN MADE BY: | Vision care benefits are funded solely by participating employees through salary reduction. Disbursements are guaranteed under a contract of insurance issued by Vision Service Plan to Loyola University New Orleans in accordance with the terms of the Plan Document and underlying insurance contract. |
| TERMINATION OR PLAN<br>AMENDMENT: | Loyola University New Orleans reserves the right to terminate or amend the plan completely or partially at any time subject to the terms and provision sof the Plan Document and underlying insurance contract. |

This form is a summary of the Plan provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Plan itself. A copy of the Plan will be furnished on request.

**DEFINITIONS:**

**ADDITONAL BENEFIT RIDER** The document attached to this Evidence of Coverage, when purchased by Group, which lists selected vision care services and vision care materials that a Covered Person is entitled to receive by virtue of the Plan.

**ANISOMETROPIA** A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.

**BENEFIT AUTHORIZATION** Authorization issued by VSP identifying the individual named as a Covered Person of VSP, and identifying those Plan Benefits to which a Covered Person is entitled.

**COPAYMENTS** Any amounts required to be paid by or on behalf of a Covered Person for Plan Benefits that are not fully covered.

**COVERED PERSON** An Enrollee or Eligible Dependent who meets VSP's eligibility criteria and on whose behalf Premiums have been paid to VSP, and who is covered under this plan.

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| **ELIGIBLE DEPENDENT** | Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by VSP under the provisions of the Plan under which such Enrollee is covered. |
| **EMERGENCY CONDITION** | A condition, with sudden onset and acute symptoms, that requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action. |
| **ENROLLEE** | An employee or member of Group who meets the criteria for eligibility specified under the provisions of the Plan. |
| **EXPERIMENTAL NATURE** | Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP. |
| **GROUP** | An employer or other entity which contracts with VSP for coverage under this plan in order to provide vision care coverage to its Enrollees and their Eligible Dependents. |
| **KERATOCONUS** | A development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area. |
| **MEMBER DOCTOR** | An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Covered Persons of VSP. |
| **NON-MEMBER PROVIDER** | Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP. |
| **PLAN BENEFITS** | The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Plan, as defined on the enclosed insert or in the Schedule of Benefits attached as Exhibit A to the Group Plan document maintained by your Group Administrator. |
| **PREMIUMS** | The payments made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached as Exhibit B to the Group Plan document maintained by your Group Administrator. |
| **RENEWAL DATE** | The date on which the Plan shall renew or terminate if proper notice is given. |
| **SCHEDULE OF BENEFITS** | The document, attached as Exhibit A to the Group Plan document maintained by your Group Administrator, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of this plan. |
| **SCHEDULE OF PREMIUMS** | The document, attached as Exhibit B to the Group Plan document maintained by your Group Administrator, which states the payments to be made to VSP by or on behalf of a Covered Person to entitle him/her to Plan Benefits. |

## BENEFITS AND COVERAGES

**IMPORTANT: The benefits described below are typical services and materials available under most VSP plans. However, the actual Plan Benefits provided to you by your Group may be different. Refer to the attached Schedule of Benefits and/or Disclosure to determine your specific Plan Benefits.**

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses.

3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.

4. Contact lenses: Visually Necessary and Elective contact lenses together with necessary professional services will be provided as indicated on the enclosed insert in lieu of spectacle lenses and frames for the current eligibility period.

**ADDITIONAL DISCOUNT**
Each Covered Person shall be entitled to receive a discount of twenty percent (20%) toward the purchase of non-covered materials from any Member Doctor when a complete pair of glasses is dispensed. Also, Covered Persons shall be entitled to receive a discount of fifteen percent (15%) off of contact lens examination services from any Member Doctor.**

Discounts are applied to the Member Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye exam.**

LIMITATIONS:

- Discounts do not apply to vision care benefits obtained from Non-Member Providers.
- 20% discount applies to complete pairs of glasses only.
- Discounts do not apply if prohibited by the manufacturer.
- Discounts do not apply to sundry items: e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

**Professional judgment will be applied when evaluating prescriptions written by another provider. Member Doctors may request a discounted additional exam.

**EXCLUSIONS AND LIMITATIONS OF BENEFITS**
This vision service plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, the Plan will pay the basic cost of the allowed lenses, and you will be responsible for the additional cost for the options, unless the extra is defined in the Schedule of Benefits attached as Exhibit A to the Group Plan document maintained by your Group Administrator.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

Although a low vision benefit is available to Insureds diagnosed as having severe visual problems (i.e., partial sight), it is subject to limitations. Consult your Member Doctor or Benefits Representative for details. **There is no benefit for professional services or materials connected with**:

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pair of glasses in lieu of bifocals.

2. Replacement of lenses and frames furnished under this Plan which are lost or broken except at the normal intervals when services are otherwise available.

3. Medical or surgical treatment of the eyes.

4. Any eye examination, or any corrective eye wear, required by an employer as a condition of employment.

5. Corrective vision treatment of an experimental nature such as, but not limited to, RK and PRK Surgery.

## ELIGIBILITY FOR COVERAGE

Enrollees: Full-time faculty or staff employees are eligible to participate in this plan on the first day of the calendar month on or following your hire date, provided you enroll within 31 days of your eligibility date. Otherwise you will not be able to enroll until the next annual enrollment period unless you experience a qualifying status change. If you are not actively at work on the date your coverage would normally begin, it will be delayed until you return to work. If both you and your spouse work for the University, you may each be covered as an employee or one of you may be covered as the other's dependent, however you may not be covered as both an employee and as a dependent. In addition, no one may be covered as the dependent of more than one employee.

Eligible Dependents: If dependent coverage is provided, the persons eligible for coverage as dependents shall include the legal spouse of any Enrollee, and any unmarried child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement in the residence of the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible from the moment of birth who has not obtained the limiting age as shown on the enclosed insert page.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon the enrollee for support and maintenance.

## ENROLLMENT FOR COVERAGE

Electing vision coverage: You can choose to enroll in the vision plan or you can choose to decline coverage. However, if you don't enroll for coverage within 31 days of your eligibility date, you will not be able to obtain coverage until the next annual enrollment period, unless you experience a change in status.

Changing vision plan coverage: Normally, you can only change your vision plan coverage (add or drop coverage for yourself or your dependents) during the annual enrollment period, which occurs prior to the end of each plan year. The choices you make during the annual enrollment period are binding for the following plan year (January 1 through December 31).

However, you can enroll or change your family coverage status before the annual enrollment period if you experience a qualifying status change that affects your benefit needs. Events that qualify as a change in status and the types of election changes that will be permitted if you experience a change in status include:

1. Marriage, birth or adoption.
2. Death, divorce, legal separation or annulment.
3. Change in your, your spouse's or your dependent's employment status.
4. A dependent child loses eligibility for coverage under the plan, i.e. marries or reaches the limiting age.
5. Loss of other employer sponsored vision plan coverage.
6. Other events as authorized by the IRS and accepted by the University.

Note that the University has the sole discretion to determine whether an election change is consistent with a change in status event.

If you experience a change in status and wish to make a change in your benefit elections, you must notify the Human Resources Department and complete the appropriate forms within 31 days of the qualifying status change event. Note that any change you make must be consistent with the event. You will be notified of any change in the amount of your contributions at that time.

## PREMIUMS

The Group is responsible for payments to VSP of the periodic charges for your coverage. You will be notified of your share of the charges, if any, by your Group. The entire cost of the program is paid to VSP by the Group.

## COPAYMENT

The benefits described herein are available to you from any participating Member Doctor, provided you follow the proper procedures by obtaining Benefit Authorization. THERE MAY BE A COPAYMENT AMOUNT PAYABLE BY YOU TO THE MEMBER DOCTOR AT THE TIME OF THE EXAMINATION. ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

## CHOICE OF PROVIDERS

Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. If you elect to receive vision care services from one of the Member Doctors, covered services are provided at no out-of-pocket cost (unless the plan contains a Copayment).

When vision care services are received from a Non-Member Provider, you will be reimbursed for such benefits according to the schedule shown on the enclosed insert, less any applicable Copayment.

## BENEFIT AUTHORIZATION PROCESS

VSP authorizes Plan Benefits according to the latest eligibility information furnished to VSP by Covered Person's Group and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for Insured by Group under this Plan. When Covered Person requests services under this Plan, Covered Person prior utilization of Plan Benefits will be reviewed by VSP to determine if Insured is eligible for new services based upon Covered Person's Plan level of coverage. Please refer to the attached Schedule of Benefits for a summary of the level of coverage provided to Covered Person by Group.

## PROCEDURE FOR USING THE PLAN

1. When you desire to receive Plan Benefits from a Member Doctor, contact VSP or the Member Doctor. If you are eligible, VSP will provide Benefit Authorization to you or the Member Doctor. If you contact a Member Doctor directly, you must identify yourself as a VSP member so that the Member Doctor can obtain the necessary Benefit Authorization from VSP.

2. When such authorization is received and services are performed prior to the expiration date of the authorization, this will constitute a claim against the Plan in spite of your termination of coverage or the termination of the Plan. Should you receive services from a Member Doctor without such authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider. VSP will reimburse you in accordance with the Non-Member Provider benefit level shown in the Schedule of Benefits and/or Additional Rider. You should submit your itemized bills identifying the group name and number, the employee (name, the patient, date(s) of service, the specific services performed and the charges, directly to VSP at the address shown on the cover of this certificate.

3. A list of Member Doctors in your geographic location can be obtained from your Group or Plan Administrator. This list contains the names, addresses, and telephone numbers of the Member Doctors. If this list does not cover the geographic area in which you desire to seek services, you may call or write VSP office nearest you to obtain one that does.

4. You pay only the Copayment (if any) to the doctor for the services covered by the Plan. VSP will pay the Member Doctor directly according to its agreement with the doctor.

5. In emergency conditions, when immediate vision care of a medical nature, such as for bodily trauma or disease is necessary, Covered Person can obtain covered services by contacting a Member Doctor (or Out-of-Network Provider - if the attached Schedule of Benefits indicates that Covered Person's Plan includes such coverage). No prior approval from VSP is required for Covered Person to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute EyeCare and Primary EyeCare Plans. If coverage for one of these plans is not indicated on the attached Schedule of Benefits or Addendum, Covered Person is not covered by VSP for medical services and should contact a physician under Covered Person's medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP's Customer Service Department for assistance. Emergency vision care is subject to the same benefit frequencies, plan allowances, Copayments and exclusions stated herein. Reimbursement to Member Doctors will be made in accordance with their agreement with VSP.

## LIABILITY IN EVENT OF NON-PAYMENT

IN THE EVENT COMPANY FAILS TO PAY THE PROVIDER, YOU SHALL NOT BE LIABLE TO THE PROVIDER FOR ANY SUMS OWED BY THE VISION Plan OTHER THAN THOSE NOT COVERED BY THE Plan.

## INDIVIDUAL CONTINUATION OF BENEFITS

This program is available to groups of a minimum of ten (10) employees and is, therefore, not available on an individual basis. When a Group terminates its coverage, individual coverage is not available for Enrollees who may desire to retain same.

## TERMINATION OF BENEFITS

Your coverage will end on the last day of the month of the first of the following to occur:

1. You are no longer eligible for coverage.
2. You cease Active Work.
3. Your last contribution for coverage was made.
4. The Policy is cancelled.

You dependents coverage will end on the last day of the month if the first of the following to occur:

1. Your coverage ends.
2. Your dependent no longer meets the plan's definition of an eligible dependent.
3. Your last contribution for dependent coverage was made.
4. The Policy is cancelled.

Terms and cancellation conditions of your vision care plan are shown on the enclosed insert. If service is being rendered to you as of the termination date of the Plan, such service shall be continued to completion, but in no event beyond six (6) months after the termination date of the Plan.

## CONTINUED COVERAGE WHILE ON CERTAIN TYPES OF UNIVERSITY-APPROVED LEAVE/ RETIREMENT

Employees who are on Sabbatical Leave, Academic Leave, or Leave of Absence Without Pay, or who are eligible for and have accepted Phased Retirement or Buy-Out, as those terms are defined by Loyola University New Orleans, may continue their vision coverage (and that of their dependents) for the length of such leave or for the period specified in the Phased Retirement/Buy Out Agreement, provided the employee continues to make regular monthly premium contributions. Contact the Loyola Human Resources Department for more information.

## CONTINUED COVERAGE DURING A FAMILY AND MEDICAL LEAVE

Your vision coverage may be continued while you are on a leave of absence protected by the Family and Medical Leave Act, provided you pay the required contributions for coverage. During unpaid leave you will need to make arrangements with the Human Resources Department to pay your contributions. The University will continue to pay the same share of your contributions as before the leave. If you do not continue coverage, your coverage will be restored when you return to work.

If you do not return to work, you may be required to reimburse the University for any contributions or premiums paid on your behalf during the leave, unless you do not return because of a serious health condition or for other reasons beyond your control, as identified in the Act.

## CONTINUED COVERAGE DURING A MILITARY LEAVE OF ABSENCE

As required by the Uniformed Services Employment and Reemployment Rights Act (USERRA), if you (the employee) take a leave of absence in order to serve in the uniformed services, you may elect to continue group vision for yourself (and your covered dependents, if any) for up to 24 months from the date your leave of absence begins.

Your USERRA continuation coverage will terminate earlier if one of the following events occurs:

- You fail to pay any premium within the required time;
- You lose your USERRA rights due to an dishonorable discharge or other conduct specified in USERRA
- You fail to report to work or to apply for reemployment following the completion of your service in the uniformed services within the time required by USERRA as described in the following chart:

| If Your Period of Uniformed Service is: | You Must Report-to-Work/Submit an Application for Reemployment Not Later Than: |
|---|---|
| Less than 31 days (or if you are absent for purposes of an examination to determine your fitness to perform uniformed services) | The beginning of the first regularly scheduled work period on the day following the completion of your service after allowing for safe travel home and an 8 hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as possible.* |
| More than 30 days but less than 181 days | 14 days after completion of your military service or if that is unreasonable or impossible through no fault of your own, as soon as possible.* |
| More than 180 days | 90 days after completion of your service.* |

*If you are hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service, the applicable time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. The maximum period for recovery generally is two years from completion of service.

USERRA and COBRA: USERRA and COBRA coverage run concurrently, which means that they begin at the same time. However, COBRA coverage can continue for up to 18 months (and for longer periods under certain circumstances) while as noted above, USERRA coverage can continue for up to 24 months. In addition, COBRA coverage is subject to early termination for additional reasons that do not apply to USERRA coverage.

Payment of Premiums: If you elect to continue health coverage under USERRA, you wil be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if your uniformed service period is less than 31 days, you are not required to pay more than the amount that you pay for such coverage as an active employee.

Whom to Contact: If you leave employment to enter military service, you should contact the Human Resources Department to determine whether you also have vision coverage continuation rights under USERRA.

**COBRA CONTINUATION**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under the law, you and your dependents may continue University-provided group vision coverage if it ends because of a life event known as a "qualifying event." COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose vision plan coverage because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries.

Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other similarly situated individuals covered by the Plan who did not have a qualifying event. If the Plan changes benefits, premiums, etc., continuation coverage changes accordingly. During annual enrollment, each qualified beneficiary will have the same options under COBRA coverage as active employees covered under the Plan.

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

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.

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

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes entitled to Medicare (Part A, Part B or both).
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare (Part A, Part B or both).
- The parents become divorced or legally separated.
- The child stops being eligible for coverage under the plan as a "dependent child."

The University will offer COBRA continuation coverage to qualified beneficiaries only after it has been notified in writing that a qualifying event has occurred. You do not have to notify the University when the qualifying event is the end of employment or reduction of hours of employment, death of the employee or entitlement to Medicare (under Part A, part B or both). **However, for the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the University, in writing, within 60 days after the qualifying event occurs. You must send this notice to the Human Resources Department at the address specified in *How to Contact the Human Resources Department*.** A notice mailed to the Human Resources Department will be considered provided on the date of mailing.

The notice must include the employee's name, the name of the spouse and/or dependent child, the nature of the qualifying event, e.g. divorce, legal separation or a child's loss of dependent status) and the date the qualifying event occurred. You will be required to provide documentation – such as a divorce decree – that a qualifying event has occurred.

**If notice is not provided during this 60-day notice period, the spouse or dependent child who loses coverage will not be offered the opportunity to elect COBRA continuation coverage.**

Once the University receives notice that a qualifying event has occurred and supporting documentation has been provided, COBRA continuation coverage will be offered to each of the qualified beneficiaries by Ceridian Benefits, the University's COBRA Administrator. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

<u>Duration of COBRA Coverage:</u> COBRA continuation coverage is a temporary continuation of coverage. The duration of the coverage depends on the nature of the qualifying event that causes the loss of coverage:

- When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

- When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare enrollment. For example, if a covered employee becomes entitled to Medicare 8 months before employment terminates, COBRA continuation coverage for the spouse and children can last up to 36 months after the date of Medicare entitlement, which would be 28 months after the date of the qualifying event (36 months minus 8 months).

- When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

<u>Disability Extension of 18-month Period of Continuation Coverage</u>: If the Social Security Administration (SSA) determines that you or anyone in your family covered under the University plan is disabled and DBI receives timely notice of that determination, you and your other family members may be entitled to received up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months of COBRA coverage. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the initial 18-month period of COBRA continuation coverage. In order for the extension to be available, you must notify Ceridian Benefits in writing of the disability determination during the first 18 months of COBRA continuation coverage and no more than 60 days after the latest of: (i) the date of the SSA determination, (ii) the date of the qualifying event or (iii) the date coverage would end on account of the qualifying event

The notice must be sent to Ceridian at the address specified in the section *How to Contact Ceridian Benefits.* It must include the employee's name, the name of the disabled individual as well as a copy of the Social Security Administration disability determination. A notice mailed to Ceridian will be considered provided on the date of mailing. **If notice is not provided within the above timeframes, the 18-month maximum coverage period will not be extended.**

The disability extension is available only for as long as the family member remains disabled. Ceridian must be notified if the Social Security Administration makes a final determination that the individual is no longer disabled. Continuation coverage will end on the first day of the month that begins more than 30 days after the date of the determination.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage: If your family experiences a second qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family may be entitled to receive an additional 18 months of COBRA continuation coverage, for a maximum of 36 months of COBRA coverage. This extension is available to the spouse and dependent children if the former employee dies, gets divorced or becomes legally separated, or if a child no longer qualifies as a dependent child under the terms of the plan, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred. Coverage will be extended only if you or your family members provide notice of the second qualifying event to Ceridian no more than 60 days after the event occurs.

This notice must be sent to Ceridian at the address specified in the section *How to Contact Ceridian Benefits*. The notice must include the employee's name, the name of the spouse and/or dependent child, the nature of the second qualifying event (e.g. divorce, legal separation or a child's loss of dependent status) and the date the qualifying event occurred (date of divorce or legal separation or the date the dependent child reached the plan's limiting age, married or lost full-time student status). A notice mailed to Ceridian will be considered provided on the date of mailing. **If notice is not provided during this 60-day notice period, COBRA continuation coverage will not be extended beyond the initial 18-month period**. You will be required to supply documentation – such as a marriage or birth certificate – that a second qualifying event has occurred.

When Continued Coverage Ends: A qualified beneficiary's COBRA continuation coverage will end before the expiration of the maximum coverage period if any of the following events occur:

- The applicable maximum coverage period expires.
- The last day of the period for which a timely payment was made.
- After the date the qualified beneficiary elected COBRA, the qualified beneficiary becomes covered under another group vision plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary. (Please notify DBI immediately if you or a dependent becomes covered under another group vision plan.)
- After the date the qualified beneficiary elected COBRA, the qualified beneficiary enrolls in Medicare.
- The employer ceases to provide any group health plan for its employees.
- In the case of the disability extension, the Social Security Administration makes a determination that the individual is no longer disabled.

Continuation coverage may also be terminated for any reason the claims administrator or insurance company would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Electing COBRA Continuation Coverage: Once the University's Human Resources Department receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. The enrollment information will come from Ceridian Benefits, the University's COBRA administrator. You and/or your spouse and dependent children will have 60 days in which to elect COBRA continuation coverage. This 60-day election period begins on the later of:

- The date coverage would end because of the qualifying event, or
- The date Ceridian Benefits provides notice of the right to elect COBRA.

A COBRA election mailed to Ceridian will be considered made on the date of mailing. **If COBRA continuation coverage is not elected during the 60-day election period, the right to elect continuation coverage will be lost.** A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

Each qualified beneficiary has an independent right to elect continuation coverage. For example, either you or your spouse may elect continuation coverage, or only one of you may choose to do so. Parents may elect to continue coverage on behalf of their dependent children only.

You may be eligible for a second COBRA election period if you did not elect COBRA continuation coverage after your termination of your employment and you later become eligible for trade adjustment assistance. In this event, you must elect COBRA during the 60-day period that begins on the first day of the month in which you are determined to be eligible for trade adjustment assistance and no more than six months after you initially lost your coverage. Contact Ceridian Benefits if you need more information about this special election period.

Coverage elected during this second election period will end 18 months from the first day of the second COBRA election period and not the date your coverage ended. The time beyond the loss of coverage and the date you became eligible for trade adjustment assistance will not be counted for purposes of determining whether you have had a 63-day break in coverage or purposes of any pre-existing condition limitation or exclusion.

Cost of COBRA Continuation Coverage: Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group vision plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent).

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under these provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Paying for COBRA Continuation Coverage: If you elect continuation coverage, you do not have to send any payment for continuation coverage with the election form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. If you do not make your first payment for continuation coverage within this 45-day period, coverage will be terminated retroactively to the beginning of the maximum coverage period and you will lose all continuation coverage rights under the plan. Premium payments should be mailed to Ceridian at the address shown in *How to Contact Ceridian Benefits.*

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. If you make a periodic payment on or before its due date, your coverage under the plan will continue for that coverage period without any break. Ceridian will provide a coupon book and return envelopes for remitting premiums after your initial premium payment – you will not receive a monthly bill. Or, to facilitate timely payment, you may set up automatic electronic debit payments from your savings or checking accounts. Instructions for this process are found on your COBRA premium computation form.

You will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, your coverage will be terminated retroactively to the first day of the month with no possibility of reinstatement.**

Benefits Under COBRA Coverage: Aside from the special rules that apply specifically to COBRA continuation, continued coverage will be exactly the same dental coverage you or your dependent would have been entitled to if your employment or his or her dependent status had not changed. If you continue COBRA coverage, you may change vision plans or add dependents on the same basis as active employees. Any future changes in benefits or the cost of coverage also will apply.

COBRA Questions: Questions concerning the plan or your COBRA continuation coverage rights should be addressed to Ceridian Benefits as indicated below. For more information about your rights under ERISA including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's website

Changes: In order to protect your family's rights, you should keep the Human Resources Department informed of any changes in the addresses of family members. If you have a qualifying event, you should also keep a copy of any notices you send to the Human Resources Department or Ceridian for your records. After electing COBRA coverage, you should also keep Ceridian informed of any changes in the addresses or dependent status of family members

How to Contact the Human Resources Department: When you experience a COBRA qualifying event, you should notify the Human Resources Department (via mail) at the following address:

Loyola University New Orleans
Attn: Human Resources/COBRA
6363 St. Charles Avenue
New Orleans, LA 70118

You can also call the Human Resources Department at (504) 864-7027 if you have any other questions about COBRA continuation coverage.

How to Contact Ceridian Benefits: The University has outsourced its COBRA administration to Ceridian Benefits. All enrollment forms and correspondence a COBRA beneficiary receives will come directly from Ceridian, and all forms, correspondence, questions, etc. should be directed to Ceridian at the following address

Ceridian COBRA Services Center
P.O. Box 534066
St. Petersburg, Florida 33747-4066
Telephone 1-800-877-7994

You can also call Ceridian Benefits at 1-800-877-7994 if you have any other questions about COBRA continuation coverage.

## COMPLAINTS AND GRIEVANCES

If you ever have a question or problem, your first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer your question and/or resolve the matter informally. If a matter is not initially resolved to your satisfaction, you may communicate a complaint or grievance to VSP, orally or in writing, by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. You also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. For complaints regarding VSP's denial of eligibility or benefits for covered services, you should follow the procedure identified below. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to the Insured to indicate VSP's expected resolution date. Upon final resolution, you will be notified of the outcome in writing.

### Claim Payments and Denials

**A.** **Initial Determination**: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

**B.** **Request for Appeals**: If the Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the Enrollee, Member Identification Number of the Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Insured believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person or Covered Person's authorized representative should submit all requests for appeals to:

**VSP**
**Member Appeals**
**3333 Quality Drive**
**Rancho Cordova, CA 95670**
**(800) 877-7195**

VSP's determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If a Covered Person disagrees with VSP's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

When a Covered Person has completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. The Covered Person should contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Covered Person has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

## OTHER FACTS YOU SHOULD KNOW ABOUT THE PLAN

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### Receive information about your plan and benefits

1. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

3. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

### Continue group health plan coverage

In addition, if you are participant in a group health plan, you have the right to:

1. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for information concerning your COBRA continuation coverage rights.

2. Receive a copy of the Plan's procedures regarding qualified medical child support orders without charge.

### Prudent actions by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

### Enforce your rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## Assistance with your questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

# *VISION SERVICE PLAN INSURANCE COMPANY*

***3333 Quality Drive***
***Rancho Cordova, CA 95670***

*Group Name:* *LOYOLA UNIVERSITY NEW ORLEANS*

*Plan Number:* *12229063*

*Effective Date:* *JANUARY 1, 2008*

*Plan Term:* *TWENTY-FOUR (24) MONTHS*

## *VISION CARE PLAN*
## *DISCLOSURE FORM AND EVIDENCE OF COVERAGE*

***PLAN ADMINISTRATOR:***

*LOYOLA UNIVERSITY NEW ORLEANS*
*(NAME)*
*PO BOX 16 6363 SAINT CHARLES AVE*
*(ADDRESS)*
*NEW ORLEANS, LA 70118-6143*
*(CITY, STATE, ZIP)*

***MONTHLY PREMIUM:***

*YOUR GROUP IS RESPONSIBLE FOR PAYMENT TO VISION SERVICE PLAN OF THE PERIODIC CHARGES FOR YOUR COVERAGE. YOU WILL BE NOTIFIED OF YOUR SHARE OF THE CHARGES, IF ANY, BY YOUR GROUP.*

***ELIGIBILITY:***

*ENROLLEES & ELIGIBLE DEPENDENTS: UNMARRIED DEPENDENT CHILDREN ARE COVERED TO AGE 21 OR TO AGE 25 IF FULL-TIME STUDENTS. THE WAITING PERIOD IS THE SAME AS YOUR OTHER HEALTH BENEFITS.*

***PLAN AND SCHEDULE:***

***PLAN C***

| | |
|---|---|
| *EXAMINATION:* | *ONCE EVERY PLAN YEAR** |
| *LENSES:* | *ONCE EVERY PLAN YEAR** |
| *FRAMES:* | *ONCE EVERY PLAN YEAR** |

**PLAN YEAR BEGINS JANUARY 1ST*

***TERM, TERMINATION AND RENEWAL:***

*AFTER THE PLAN TERM, THIS PLAN WILL CONTINUE ON A MONTH TO MONTH BASIS OR UNTIL TERMINATED BY EITHER PARTY GIVING THE OTHER SIXTY (60) DAYS PRIOR WRITTEN NOTICE.*

***TYPE OF ADMINISTRATION:***

*BENEFITS ARE FURNISHED UNDER A VISION CARE PLAN PURCHASED BY THE GROUP AND PROVIDED BY VISION SERVICE PLAN (VSP) UNDER WHICH VSP IS FINANCIALLY RESPONSIBLE FOR THE PAYMENT OF CLAIMS.*

***VSP'S ADDRESS IS:***

*VISION SERVICE PLAN*
*3333 QUALITY DRIVE*
*RANCHO CORDOVA, CA 95670*

## *SCHEDULE OF BENEFITS*

***GENERAL***

*This Schedule and any Additional Benefit Rider(s), when purchased by Group, attached hereto list the vision care services and vision care materials to which Covered Persons of VSP are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. If Plan Benefits are available for Non-Member Provider services as indicated by the reimbursement provisions below, vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers.*

*When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayment(s) as stated below. When Plan Benefits are available and received from Non-Member Providers, you are reimbursed for such benefits according to the schedule in the second column below less any applicable Copayment.*

| ***PLAN BENEFITS*** | ***MEMBER DOCTOR BENEFIT*** | ***NON-MEMBER PROVIDER BENEFIT*** |
|---|---|---|
| ***VISION CARE SERVICES*** | | |
| *Vision Examination* | *Covered in Full** | *Up to $ 35.00** |
| ***VISION CARE MATERIALS*** | | |
| *Lenses* | | |
| *Single Vision* | *Covered in Full** | *Up to $ 25.00** |
| *Bifocal* | *Covered in Full** | *Up to $ 40.00** |
| *Trifocal* | *Covered in Full** | *Up to $ 55.00** |
| *Lenticular* | *Covered in Full** | *Up to $ 80.00** |
| *Frames* | *Covered up to Plan Allowance** | *Up to $ 45.00** |

*Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or Custom LASIK patients.*

| ***CONTACT LENSES*** | | |
|---|---|---|
| *Visually Necessary Professional Fees and Materials* | *Covered in Full** | *Up to $ 210.00** |
| *Elective Professional Fees** and Materials* | *Up to $ 120.00* | *Up to $ 105.00* |
| ***LENS OPTIONS*** | | |
| *Tinted/Photochromic* | *Covered in Full* | *Up to $ 5.00* |

***Subject to Copayment, if any.**

****Additional discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.***

***COPAYMENT***

*There shall be a Copayment of $10.00 for the examination payable by the Covered Person to the Member Doctor at the time services are rendered. If materials (lenses and frames) are provided, there shall be an additional $25.00 Copayment payable at the time the materials are ordered. However, the Copayment for materials shall not apply to Elective Contact Lenses.*

***LOW VISION***

*Professional services, as necessary, for severe visual problems not corrected with regular lenses, including:*

| | | |
|---|---|---|
| *Supplemental Testing* | *Covered in Full* | *Up to $125.00* |
| *(includes evaluation, diagnosis and prescription of vision aids where indicated)* | | |
| *Supplemental Aids* | *75% of cost* | *75% of cost* |

*Maximum allowable for all Low Vision benefits of $1000.00 every two (2) years.*

***ADDITIONAL DISCOUNT***

*Each Covered Person shall be entitled to receive a discount of twenty percent (20%) toward the purchase of non-covered materials from any Member Doctor when a complete pair of glasses is dispensed. Also, Covered Persons shall be entitled to receive a discount of fifteen percent (15%) off of contact lens examination services from any Member Doctor.***

*Discounts are applied to the Member Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye exam.***

*LIMITATIONS:*

- *Discounts do not apply to vision care benefits obtained from Non-Member Providers.*
- *20% discount applies to complete pairs of glasses only.*
- *Discounts do not apply if prohibited by the manufacturer.*
- *Discounts do not apply to sundry items: e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.*

***Professional judgment will be applied when evaluating prescriptions written by another provider. Member Doctors may request a discounted additional exam.*

***THIS EVIDENCE OF COVERAGE CONSTITUTES ONLY A SUMMARY OF THE VISION PLAN. THE VISION PLAN DOCUMENT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE.***

**Exhibit C**

## ADDITIONAL BENEFIT RIDER
## PRIMARY EYECARE PLAN

### GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN INSURANCE COMPANY ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. This Rider forms a part of the Policy and Evidence of coverage to which it is attached.

The Primary EyeCare Plan is designed for the detection, treatment and management of ocular conditions and/or systemic conditions that produce ocular or visual symptoms. Under the Plan, Member Doctors provide treatment and management of urgent and follow-up services. Primary EyeCare also involves management of conditions that require monitoring to prevent future vision loss.

The Member Doctor is responsible for advising and educating patients on matters of general health and prevention of ocular disease. If consultation, treatment, and/or referral are necessary, it is the responsibility of the Member Doctor as a Primary EyeCare professional, to manage and coordinate on behalf of the patient to assure appropriateness of follow-up services.

Covered Persons with the following symptoms and/or conditions (see DEFINITIONS, below) will be covered for certain Primary EyeCare services in accordance with the optometric scope of licensure in the Member Doctor's state. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

### SYMPTOMS

Examples of symptoms which may result in a patient seeking services on an urgent basis under the Primary EyeCare Plan include, but are not limited to:

- ocular discomfort or pain
- transient loss of vision
- flashes or floaters
- ocular trauma
- diplopia
- recent onset of eye muscle dysfunction
- ocular foreign body sensation
- pain in or around the eyes
- swollen lids
- red eyes

### CONDITIONS

Examples of conditions which may require management under the Primary EyeCare Plan include, but are not limited to:

- ocular hypertension
- retinal nevus
- glaucoma
- cataract
- pink-eye
- macular degeneration
- corneal dystrophy
- corneal abrasion
- blepharitis
- sty

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

## PROCEDURES FOR OBTAINING PRIMARY EYECARE SERVICES

To obtain Primary EyeCare Services, the Covered Person contacts a Member Doctor's office and makes an appointment. If necessary, the Covered Person may first call VSP's Customer Service Department to determine the location of the nearest Member Doctor's office.

If urgent care is necessary, the Covered Person may be seen by a Member Doctor immediately.

The Covered Person pays the applicable Copayment to the Member Doctor at the time of each Primary EyeCare office visit, and for any additional services not covered by the Plan.

Upon completion of the services, the Member Doctor will submit the required claim information to VSP. VSP will pay the Member Doctor directly in accordance with VSP's agreement with the doctor.

See schedule below for Plan Benefits, payments and/or reimbursement subject to any Copayment(s) as stated.

## COPAYMENT

A Copayment amount of $5.00 shall be payable by the Covered Person at the time of each Primary EyeCare office visit.

## REFERRALS BY THE MEMBER DOCTOR

The Member Doctor will refer the Covered Person to another doctor under the following circumstances:

If the Covered Person requires additional services which are covered by the Primary EyeCare Plan but can not be provided in the Member Doctor's office, the doctor will refer the Covered Person to another Member Doctor or to the Group's major medical physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of the Primary EyeCare Plan, the Member Doctor will refer the Covered Person to the Group's major medical physician.

If the Covered Person requires emergency services beyond the scope of the Primary EyeCare Plan, the Member Doctor will make an urgent referral by calling either another Member Doctor or the Group's major medical physician.

## EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Primary EyeCare Plan is designed to cover Primary EyeCare services only. There is no coverage provided under the Plan for the following:

- Costs associated with securing materials such as lenses and frames.
- Orthoptics or vision training and any associated supplemental testing.
- Surgical or pathological treatment.
- Any eye examination, or any corrective eyewear required by an employer as a condition of employment.
- Medication.
- Pre- and post-operative services.
- Services and/or materials not indicated on this Rider as covered Plan Benefits.

DEFINITIONS

| | |
|---|---|
| Blepharitis | Inflammation of the eyelids. |
| Cataract | A cloudiness of the lens of the eye obstructing vision. |
| Conjunctiva | The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye. |
| Corneal Abrasion | Irritation of the transparent, outermost layer of the eye. |
| Corneal Dystrophy | A disorder involving nervous and muscular tissue of the transparent, outermost layer of the eye. |
| Diplopia | The observance by a person of seeing double images of an object |
| Eye Muscle Dysfunction | A disorder or weakness of the muscles that control the eye movement. |
| Flashes or Floaters | The observance by a person of seeing flashing lights and/or spots. |
| Glaucoma | A disease of the eye marked by increased pressure within the eye which causes damage to the optic disc and gradual loss of vision. |
| Macula | The small, sensitive area of the central retina, which provides vision for fine work and reading. |
| Macular Degeneration | An acquired degenerative disease which affects the central retina. |
| Ocular | Of or pertaining to the eye or the eyesight. |
| Ocular Conditions | Any condition, problem, or complaint relating to the eyes or eyesight. |
| Ocular Hypertension | Unusually high blood pressure within the eye. |
| Ocular Trauma | A forceful injury to the eye due to a foreign object. |
| Pink eye | An acute, highly contagious inflammation of the conjunctiva. |
| Retinal Nevus | A pigmented birthmark on the sensory membrane lining the eye that receives the image formed by the lens. |
| Systemic Condition | Any condition or problem relating to a person's general health. |
| Sty | An inflamed swelling of the fatty material at the margin of the eyelid. |
| Transient Loss of Vision | Temporary loss of vision. |