

UNIVERSITY OF MISSOURI SYSTEM
Vision Benefit Plan

Effective January 1, 2019



This summary plan description is designed to provide an overview of the Vision Benefit Plan (Plan). While the University hopes to offer participation in this plan indefinitely, it has the right to amend or terminate any benefit plan. In addition to this SPD, the University plans to continue to use other methods of communication such as memos, meetings, or newsletter articles to help you stay informed.

This SPD serves as both the Plan document and SPD. This SPD is designed to meet your information needs. It supersedes any previous printed or electronic SPD for this Plan. The terms of this Plan may not be amended by oral statements made by the Plan Sponsor, the Claims Administrator, or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control.

It's important for you to have a good understanding of all this plan has to offer. Please review this SPD carefully. If you have questions, contact your HR Generalist or HR Service Center at the appropriate address or phone number shown below.

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Introduction

The Vision Benefit Plan is designed to help you meet vision care expenses and to encourage you to include eye care as part of your regular health care routine. You may select from either the Vision Insurance Plan or the Discount Plan.

The Plan provides payment for covered vision expenses for you and your eligible dependents. The Plan offers specific coverage with designated copay and allowance amounts for materials and services obtained from EyeMed providers. The Plan does give allowances when you obtain services and materials from non-network providers.

Unless otherwise stated the rules apply to retirees where employees are mentioned.

Summary of Vision Care Services – EyeMed Vision Insurance Plan

Schedule of Benefits

Benefit	Benefit Frequency	In-Network	Non-Network
Comprehensive Eye Examination (with Dilation as Necessary)	Once per calendar year	\$10 copayment	Reimbursed up to \$45 after \$10 copayment
Retinal Imaging		Up to \$39	N/A
Materials			
Frames	Once every other calendar year	\$0 copayment + \$140 allowance and 20% off balance over \$140	Reimbursed up to \$47
Lenses Only one type of lens will be covered every calendar year.			
Single vision Lenses	Once per calendar year	\$25 copayment	Reimbursed up to \$45 after \$25 copayment
Bifocal Lenses	Once per calendar year	\$25 copayment	Reimbursed up to \$65 after \$25 copayment
Trifocal Lenses	Once per calendar year	\$25 copayment	Reimbursed up to \$85 after \$25 copayment
Standard Progressive Lens	Once per calendar year	\$80 copayment	Reimbursed up to \$65 after \$25 copayment
Premium Progressive Lens — Tier 1 — Tier 2 — Tier 3 — Tier 4	Once per calendar year	\$100 copayment \$110 copayment \$125 copayment \$80 copayment; 20% off retail less \$120 allowance	Reimbursed up to \$65 after \$25 copayment
Lenticular Lenses	Once per calendar year	\$25 copayment	Reimbursed up to \$125 after \$25 copayment

Benefit	Benefit Frequency	In-Network	Non-Network
Lens Option			
paid by the member and added to the base price of the lens			
UV Treatment	Once per calendar year	\$15 copayment	N/A
Tint (Solid and Gradient)	Once per calendar year	\$15 copayment	N/A
Standard Plastic Scratch Coating	Once per calendar year	\$15 copayment	N/A
Standard Polycarbonate	Once per calendar year	\$40 copayment	N/A
Standard Polycarbonate—Kids under 19	Once per calendar year	\$0 copayment	N/A
Standard Anti-Reflective Coating	Once per calendar year	\$45 copayment	N/A
Premium Anti Reflective Coating — Tier 1 — Tier 2 — Tier 3	Once per calendar year	\$57 copayment \$68 copayment 80% of charge	N/A
Photochromic/Transitions	Once per calendar year	\$75 copayment	N/A
Polarized	Once per calendar year	20% off retail price	N/A
Contact Lenses (in lieu of lenses)			
Contact Lens Fit and Follow up* — Standard — Premium	Once per calendar year	Up to \$40 10% off retail	N/A
Contact Lenses** — Conventional — Disposable — Medically Necessary	Once per calendar year	\$140 allowance; 15% off balance over \$140 \$140 allowance; plus balance over \$140 Paid-in-Full	Up to \$130 Up to \$130 Up to \$210
*contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed			
** \$0 Copayment			

Low Vision (Effective 3.1.18)			
All Low Vision services are subject to prior approval by EyeMed.			
Professional services, as necessary, for severe visual problems not correctable with regular lenses.			
Benefit	Frequency	Network	Non-Network
Supplemental Testing	24- month Benefit Period	Covered in Full	Up to \$125
Low Vision Aids	24- month Benefit Period	25% copayment up to \$1,000	25% copayment up to \$1,000 allowance

Extra Discounts and Savings

EyeMed offers discounts for members enrolled in the Vision Insurance Plan

Under the Vision Insurance Plan, you may receive benefits for eyeglasses (frame and lenses) or contact lenses as outlined on the Summary of Vision Care Services. In addition, EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been used. The in-network discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the Plan at network providers

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy.

Discounts on services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered.

Medically Necessary Contact Lenses

The Plan provides coverage for medically necessary contact lenses when one of the following conditions exists:

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding -10D or +10D in meridian powers
- **Keratoconus** where the member's vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses
- **Vision Improvement** for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

Savings on Laser Vision Correction

EyeMed Vision Care, in connection with the U.S. Laser Network, owned and operated by LCA Vision, offers discounts to you for LASIK and PRK. You receive a discount when using a network provider in the U.S. Laser Network. The U.S. Laser Network offers many locations nationwide. For additional information or to locate a network provider, visit www.eyemedlasik.com or call **1-877-5LASER6**.

After you have located a U.S. Laser Network provider, you should contact the provider, identify yourself as an EyeMed member and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at **1-877-5LASER6** to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to the U.S. Laser Network. Upon receipt of the deposit, and prior to treatment, the U.S. Laser Network will issue an authorization number to your provider. Once you receive treatment, the deposit will be deducted from the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the remaining balance of the fee. Should you decide against the treatment, the deposit will be refunded.

You are responsible for scheduling any required follow-up visits with the U.S. Laser network provider to ensure the best results from your laser vision correction procedure.

Hearing Discount Benefit with Amplifon Hearing Health Care

EyeMed has partnered with Amplifon – the world's largest distributor of hearing aids and services – to add affordable hearing care to your EyeMed vision benefits package. Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids. For additional information, call **1-844-526-5432**

Online Contact Lenses with ContactsDirect.com

You can apply your in-network contact lens benefit at contactsdirect.com. Simply complete the online transaction form and the contacts will be delivered directly to your home.

Online Eyewear with Glasses.com

To make sure you get easy, convenient access to vision choices that best fit your lifestyle, EyeMed members can now apply in-network vision benefits from anywhere, anytime at Glasses.com. For additional information visit www.glasses.com.

EyeMed Providers

EyeMed's network of providers includes private practitioners, as well as the nation's premier retailers, LensCrafters®, Sears Optical, Target Optical, JCPenney Optical and most Pearle Vision locations. To locate EyeMed Vision Care providers near you, visit www.eyemed.com and choose the Insight Network. You may also call EyeMed's Customer Care Center at 1-866-800-5457. EyeMed's Customer Care Center can be reached Monday through Saturday 7:30 am to 11:00 pm EST and Sunday 11:00 am to 8:00 EST.

Access to Services and Materials

When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization or Plan number, located on the front of your ID card. Confirm the provider is an in-network provider for the Insight Network. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to identify your membership in the Plan.

Payment for Services

Network Services

When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Non-Network Services

If you receive services from an out-of-network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Summary of Vision Care Services. A claim must be submitted within 15 months of the date of service. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to First American Administrators, Inc., ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care:

FAA/EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

For your convenience, a FAA/EyeMed out-of-network claim form is available at www.eyemed.com or by calling EyeMed's Customer Care Center at 1-866-800-5457.

Benefit Summary – Discount Option

The Discount Option is only available to employees/retirees and their family if no one in the family is enrolled in the Vision Insurance plan. There is no premium cost to the Discount Option. To receive the discount, you must visit an EyeMed provider and reference the plan number: 1015037.

Exam with Dilation as Necessary	Frequency: Unlimited
\$5 off routine exam	
\$10 off contact lens exam	
Frame discount*	Frequency: Unlimited
35% off retail price	
Standard Plastic Lenses*	Frequency: Unlimited
Single vision \$50	
bifocals \$70	
trifocals \$105	
Lens Options*	Frequency: Unlimited
UV Treatment \$15	
Tint (Solid and Gradient) \$15	
Standard Plastic Scratch Coating \$15	
Standard Polycarbonate \$40	
Standard Progressive (Add-on to Bifocal) \$65	
Standard Anti-Reflective Coating \$45	
Other Add-On and Services 20% Discount	
Contact Lenses (Allowance includes materials only)	Frequency: Unlimited
Conventional 15% off retail price	
Disposable 0% off retail price	
Laser Vision Correction	
LASIK or PRK from US Laser Network 15% off the retail price of 5% off the promotional price	
*Complete Pair of Glasses Purchase: frame, lenses and lens options must be purchased in the same transaction to receive full discount.	
The discount option is only available from an EyeMed provider.	

Exclusions

No benefits will be paid for services or materials connected with or charges arising from the following excluded services and/or materials under the Vision Plan:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes or supporting structures;
- Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- Plano (non-prescription) lenses;
- Non-prescription sunglasses;
- Two pair of glasses in lieu of bifocals;
- Services or materials provided by any other group benefit plan providing vision care;
- Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Claims Questions

You may authorize someone else to file and pursue a claim for benefits or an appeal on your behalf. If you do so, you must notify EyeMed Vision Care in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number, and a statement indicating the extent to which he or she is authorized to act on your behalf. A consent form that you may use for this purpose will be provided to you upon request.

Time Frames for Processing Claims

First American Administrators, Inc., ("FAA"), a wholly-owned subsidiary of Eye Med Vision Care, will decide claims within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If FAA needs additional time to decide a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing.

Time Frames and Procedures for Appealing Claims – First Level

If your claim is denied, in whole or in part, you may file a first-level appeal. The first-level appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit a first-level appeal within 180 days after this 30-day period has expired. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the written denial or a copy of the EOB, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care provider that will assist FAA in completing its review of the member's first-level appeal, such as documents, records, questions or comments.

The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

FAA/EyeMed will review your first-level appeal and notify you in writing of its decision.

Time Frames for and Procedures for Appealing Claims – Second Level

NOTE: This second-level appeal applies only if permitted by applicable state law. If your first-level appeal is denied, in whole or in part, you may file a second-level appeal. The second-level appeal must be in writing and received by FAA within 180 days after the denial of your first-level appeal. If you do not receive first-level appeal decision within 60 days after it was filed, you may submit a second-level appeal within 180 days after this 60-day period has expired. Your written letter of appeal should include the same items detailed above, plus any new information that you believe supports your position.

The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

FAA/EyeMed will review your second-level appeal and notify you in writing of its decision.

Complaint Procedure

If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility or with EyeMed's Plan administration, you should first call EyeMed Customer Care Center at 1-866-800-5457 to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at the address noted above. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint 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 EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

The Insured benefits are underwritten by Fidelity Security Life Insurance Company. Discounts are provided by EyeMed Vision Care. If you have any questions or concerns, please contact EyeMed Vision Care at www.eyemed.com or 1-866-800-5457.

Eligibility for Coverage

Active Employee Eligibility

If you are an active employee or subsidiary employee (CRR 320.050) of the University, you are eligible for coverage, provided you also meet the following conditions:

- You are classified .75 FTE or more.
- You have an appointment duration of at least nine months.
- You are regularly scheduled to work at least 30 hours a week.

For the purpose of this section any individual who is simultaneously employed by the University and the Harry S. Truman Veterans Administration Hospital pursuant to an agreement between said organizations, and whose joint appointments, combined, otherwise meet the requirements of this section, shall be considered an Employee.

In addition, you are eligible for coverage under this plan if you are:

- An individual who, while covered as an Employee under the sections described above, became totally and permanently disabled in accordance with the University's Long Term Disability Plan and is entitled to continued service credit as a disabled Employee under the University's Retirement, Disability and Death Benefit Plan.

A per diem employee is excluded as an Employee under this Plan.

Retiree Eligibility

If you are a retiree of the University, you are eligible for coverage, provided you also meet the following requirements:

- You retired on or before 12/31/17, you are eligible for postretirement benefits at the earlier of:
 - Age 55 and at least 10 years of service, or
 - Age 60 and at least 5 years of service
- Effective January 1, 2018, the eligibility for postretirement benefits are as follows:
 - Must be employed in a UM System benefit eligible position on December 31, 2017; and
 - At least five years of service as of December 31, 2017, and
 - At least 60 years old on his/her retirement date; and
 - At least 20 years of service to the UM System on his/her retirement date.

If you were covered under the respective plan(s) immediately prior to your retirement, you are eligible to continue coverage provided you make written application to participate as a retiree within 31 days of retirement.

If after retirement you become reemployed by the University or a University Subsidiary Entity and you become eligible for coverage as an Employee under University-sponsored active Employee insurance plans, your eligibility for all retiree coverage will “freeze” beginning the first of the following month after your effective date of becoming eligible for coverage as an Employee, unless your effective date is the first of the month, then, coverage will “freeze” on the first of that month. Upon your termination from regular employment and loss of University-sponsored active Employee insurance coverage (or upon loss of University-sponsored active Employee insurance coverage even while you are still employed, because you no longer meet the eligibility requirements for coverage as an Employee), you must **immediately re-enroll in the retiree insurance coverage** in which you are eligible or you will forfeit your right to re-enroll at a later date.

Dependent Eligibility

Note: Proof of relationship documentation is required for spouse or sponsored adult dependent and children to be covered. If you fail to provide requested documentation, you may be liable for vision claims or premiums back to the date you enrolled.

Your eligible dependents include your spouse or sponsored adult dependent and each of your natural children, stepchildren, foster children, adopted children, or child placed in your home for adoption younger than age 26 (note the term “stepchild” does not include the children of your sponsored adult dependent).

If your child is dependent on you because of a physical or mental disability, they may remain covered by the Plan as long as they remain incapacitated. The child must be unmarried, dependent on you or your spouse or sponsored adult dependent for principal financial support, and incapable of self-sustaining employment prior to reaching the maximum age for coverage as a dependent. In this situation, you must notify the University and submit proof of the child's status within 31 days prior to the date he or she would otherwise become ineligible.

If you are eligible for coverage based on your employment with the University, you may be covered under your own employment or you may be covered as a dependent. You may not be covered both as a dependent and as an employee.

If you and your spouse or sponsored adult dependent both work for the University and you have children, only one of you may claim the children as covered dependents.

For the purposes of this Plan, your “sponsored adult dependent” means an adult person who meets all of the following criteria:

- has had the same principle residence as you for at least 12 months, and continues to have the same principle residence as you, disregarding temporary absences due to special circumstances including illness, education, business, vacation or military service;
- is 18 years of age or older;
- is not currently married to another person under either statutory or common law;
- is not related to you by blood or a degree of closeness that would prohibit marriage in the law of the state in which you reside.

Premium Payment

As an employee and/or retiree you pay the full cost of the premium for vision coverage.

If you are an employee, your contribution will be made on a before-tax basis for yourself, your spouse, and any eligible dependent children, which lowers the current income taxes you pay, unless you choose to contribute on an after-tax basis. Your contribution for a sponsored adult dependent will be on an after-tax basis unless the sponsored adult dependent is a qualified tax dependent under IRS rules. Please note that retirees may only make premium payments on an after-tax basis. For more details about how the before-tax feature works, refer to your Flexible Benefits Plan SPD.

Coverage Begin Date

Employees

Coverage begins on the date of hire or the benefit eligibility date provided you submit the form within 31 days of your date of hire or eligibility date.

If you change from part-time to full-time or from temporary to permanent status and become benefit eligible, you must enroll within 31 days of the date of your change in status.

If you are not actively at work on the date your coverage would normally begin, the coverage will not be effective until you return to full-time active employment unless you are not actively at work due to a health factor.

Retirees

If you retire on the first of the month, your retiree coverage eligibility begins on that day. If you retire beyond the first of the month, retiree coverage eligibility will begin on the first of the month following your retirement date provided you were enrolled in the coverage at the time of retirement and submit the plan enrollment form to participate as a retiree within 31 days of retirement.

If you elect coverage during Annual Enrollment, coverage begins on the first of the year following the Annual Enrollment period.

Dependents

Dependent coverage becomes effective on the date the employee personal coverage becomes effective, provided you have completed and returned the Plan enrollment form with each dependent's name and Social Security number listed. If, after your coverage becomes effective, you acquire a new dependent — by marriage, for example — you have 31 days to obtain coverage by completing the appropriate enrollment form and returning it to your HR Generalist or HR Service Center.

In the case of an adopted child or a child placed in your home for adoption, you also have 31 days to obtain coverage from the date the child is placed in your custody.

It is your responsibility to notify the University of the addition of a dependent or of any changes in your family status. Contact your Total HR Generalist or HR Service Center to obtain any necessary forms.

In instances where applications for enrollment are submitted subsequent to 31 days following the initial date of eligibility, two situations may apply:

1. If a specific premium contribution is required for coverage (i.e., coverage for other children did not already exist), coverage will become effective on the date a properly completed enrollment form (including proof of relationship) is submitted to your HR Generalist or HR Service Center *provided* it is done so within 180 days from the date the child was first eligible. If the enrollment form is submitted after 180 days, coverage will not become effective until the following January 1.
2. If a specific premium is not required for coverage (i.e., coverage already exists for other eligible dependent children), coverage will be made effective on the date the child first became eligible for coverage. However, before claims can be paid, a properly completed enrollment form (including proof of relationship) must be submitted to your HR Generalist or HR Service Center.

Retirees: Dependent Coverage becomes effective on the date your retiree coverage becomes effective, assuming you covered the dependent immediately prior to retirement and you have completed and returned the Plan Enrollment Form with each Dependent's name and social security number listed within 31 days of your Retirement. Proof of relationship documentation is required for spouse or sponsored adult dependent and children to be covered. In the event that Your Spouse or Sponsored Adult Dependent is also a University of Missouri benefit eligible Employee who separates from the university and/or loses eligibility for retiree vision insurance, you may add your Spouse or Sponsored Adult Dependent as a Dependent to your retiree vision insurance (and any eligible Dependent Children) if they were enrolled in active vision insurance under your Spouse's coverage as an eligible Employee. You must make written application (including proof of relationship)

for such Spouse or Sponsored Adult Dependent and eligible Dependent Children within 31 days after the change in status. Coverage will become effective on the first of the month following the date of the event (provided the necessary forms are submitted to the University).

Changing Coverage - Qualifying Family/Employment Status Changes

You may change your coverage level (including beginning or ending coverage or adding or dropping dependents) during the Plan year only if you have a qualifying family/employment status change.

Qualifying family/employment status changes are limited to:

- Marriage, divorce, legal separation or annulment
- Death of a spouse or sponsored adult dependent
- A change in the number of dependent children as a result of birth, death, adoption or placement of a child for adoption
- The termination or commencement of employment of your spouse or sponsored adult dependent
- A change in your work schedule, or that of your spouse or sponsored adult dependent, that involves an increase or decrease in work hours, a strike, a lockout or an unpaid leave of absence
- A change in residence or worksite location of you, or your spouse or sponsored adult dependent
- Receipt by the University of a valid Notice of Order to Enroll under Missouri law
- A change in entitlement to Medicare or Medicaid for you, your spouse or sponsored adult dependent or a dependent child
- A significant change in health coverage provided by your spouse or sponsored adult dependent's employer that affects you or your spouse or sponsored adult dependent
- A leave of absence under the Family and Medical Leave Act of 1993 (FMLA)

If any of these qualifying family/employment status changes occur, you may change your level of coverage provided the change is consistent with the status change itself. Contact your HR Generalist or HR Service Center to complete the appropriate form, which must be completed and returned within 31 days of the date of the status change. After that, changes can be made only during the Annual Enrollment change period, except as required by the Health Insurance Portability and Accountability Act (HIPAA), described later in this section.

Benefit changes, when made within 31 days as described above, will be effective as follows:

- Changes due to birth, adoption, placement of a child for adoption or death will be effective on the date of the event.
- Changes resulting from all other qualifying family/employment status changes will be effective on the day the completed enrollment form is received by your HR Generalist or HR Service Center.

Under the Health Insurance Portability and Accountability Act, you or an eligible dependent may also enroll for coverage if:

1. You are an eligible dependent declined coverage under the University plan because you had other coverage, *and*
2. The other coverage ends, *and*
3. You contact your HR Generalist or HR Service Center and complete an enrollment form and provide written proof that the other coverage ended for the individual involved within 31 days after this event occurs.

OR

1. You declined coverage under the University Plan because you had other coverage, *and*
2. Your dependents other coverage ends, *and*
3. You contact your HR Generalist or HR Service Center and complete an enrollment form and provide written proof that the other coverage ended for the individual involved within 31 days after this event occurs.

OR

1. Due to marriage, birth, adoption or placement for adoption- for these specific situations eligible dependents include your spouse or sponsored adult dependent and newly acquired child/ren dependent/s (existing child dependents are not eligible for enrollment). You must enroll within 31 days of the event. This is called a *special enrollment period*. Coverage will be effective on the date of the

event provided your enrollment form is received by your HR Generalist or HR Service Center within 31 days of the date of the event.

Retirees: Retirees are not eligible to add Dependents to their vision plan coverage after the date of retirement due to a qualifying family/employment status change, unless the Retiree's Spouse/Sponsored Adult Dependent is also a University of Missouri benefit eligible employee who was enrolled in active vision insurance under their own eligibility (including dependent children) and separates from the university and/or loses eligibility for retiree vision insurance. Please keep in mind, the newly covered Spouse/Sponsored Adult Dependent and any eligible Child(ren) are eligible only for continued coverage in this plan, if they were enrolled in active vision insurance under your Spouse's coverage as an eligible Employee. All other enrollments and/or changes to vision coverage may only occur during Retiree Annual Enrollment and are effective January 1 of the following year.

Coverage Termination

Your vision coverage will end on the earlier of the following dates:

- On the last day of the month of the employment termination
- When you are no longer eligible for coverage
- When you cease making the required vision plan contribution
- When the University terminates the Plan

Your dependent's coverage will terminate on the earliest of the following dates:

- When all dependent coverage under the Plan terminates
- When the individual no longer meets the Plan's definition of a dependent
- When your coverage terminates
- When you cease making the required contribution for dependent coverage

Note: You may not discontinue dependent coverage during the year when the dependent continues to be eligible for coverage unless the change is in connection with a family status change.

Coverage after Employee Death

If you die while actively employed by the University and after becoming vested in the University Retirement Plan (completed at least 5 years of creditable service), or if you would be vested if you were covered under the University Retirement Plan instead of the Civil Service Retirement Plan or the Federal Employees Retirement Plan, your eligible spouse or sponsored adult dependent may continue coverage after your death. In addition, the continuation of coverage is available for your children, but only when spouse or sponsored adult dependent coverage is also continued. The continuation of coverage under this provision is subject to the payment of monthly contributions by the spouse or sponsored adult dependent. An eligible spouse, for the purposes of this provision is the spouse to whom you were married on the date of your death, provided you had been married to this spouse for at least one year preceding your death. An eligible sponsored adult dependent, for the purposes of this provision is the sponsored adult dependent for whom you provided an affirmation with the university of a sponsored adult partnership at least one year preceding your death.

If you die after retirement from the University, your eligible spouse or sponsored adult dependent may continue coverage after your death, as described above, including coverage for your children. It is important to note, however, that the coverage for the spouse or sponsored adult dependent of a retiree is available only to the person to whom the retiree was married or had an affirmation of sponsored adult partnership with the University on the day preceding the date of retirement.

No continued coverage is available for children unless the spouse or sponsored adult dependent is also covered.

Enrollment for continued coverage must be made within 31 days after your death.

Continued coverage will terminate on the earliest of:

- the date the individual no longer meets this plan's definition of an eligible dependent
- the date all dependent coverage is discontinued under this plan with respect to your class of eligible employees
- the end of the period for which any required contributions have been made

Continuation of Vision Plan Coverage (COBRA)

Federal law, pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires the Plan to offer covered employees and dependents the opportunity to continue Vision Plan coverage when the individual's coverage ends for certain specified reasons. The following provisions outline the requirements for continued coverage in accordance with the law. These provisions apply only to the extent that the required period of continued coverage has not already been provided under other plan provisions.

Eligibility for Continued Coverage

An employee and covered dependents may continue vision coverage for up to 18 months if coverage ends because of either a reduction in the number of hours worked or termination of employment for any reason other than gross misconduct.

Dependents may continue their vision coverage under the group plan for up to 36 months if their coverage ends for any of the following reasons:

- divorce or legal separation from the employee
- the death of the employee
- the dependent child reaches the limiting age or otherwise ceases to qualify as a dependent under the Plan

These periods of continued coverage begin on the date of the event that caused loss of coverage, for instance, the date you leave the company or the date a dependent becomes ineligible.

In no event will more than a total of 36 months of continued coverage be provided to any individual, even if more than one of the above events occurs.

Continued coverage ends automatically if any of the following occur:

- the cost of continued coverage is not paid on or before the date it is due
- an individual becomes covered under another group vision plan, unless coverage under the other plan is limited due to the individual's pre-existing condition
- the Plan terminates for all employees
- the applicable maximum coverage period ends

Extension of Maximum Coverage Period

Disabled individuals

An exception applies if an employee or a dependent is determined to be totally disabled during the first 60 days of continued vision coverage due to a reduction in hours worked or termination of employment. The maximum coverage period for the disabled individual will be 29 months, rather than 18 months. In order to be eligible for the extended period, the disabled individual must meet the definition of disability under the Social Security Act and notify the University during the first 18 months of continued coverage and within 60 days after the date of determination of disability has been made by Social Security. (The disabled individual is required to notify the University within 30 days after any final determination by the Social Security Administration that the individual is no longer disabled.)

Dependents of an employee entitled to Medicare

If an employee becomes entitled to Medicare, the maximum coverage period for dependents will not end until at least 36 months after the date on which the employee became entitled to Medicare.

Divorced or widowed spouses or sponsored adult dependents at least age 55

Medical coverage can continue beyond the COBRA period if the continuation coverage under the Plan expires when a divorced or widowed spouse or sponsored adult dependent is at least age 55. Coverage can continue for the spouse or sponsored adult dependent and eligible dependents until the sponsored adult dependent reaches age 65.

Application for Continued Coverage

When the HR Generalist or HR Service Center is notified that one of these events has happened, you will be sent an election form notifying you of the conditions that apply to continued coverage.

However, in the event you become divorced or legally separated, or when your dependent child no longer qualifies as a covered dependent under the Plan, you or your covered spouse or sponsored adult dependent or your covered child must notify the HR Generalist or HR Service Center within 60 days. If you fail to do this, your dependent's rights to continued coverage will be forfeited.

Continued coverage is not automatic. You must submit the completed election form within 60 days from the later of the following dates:

- the date you cease to be eligible under the group plan
- the date you receive the election form

Cost of Continued Coverage

Any person who elects to continue coverage under the Plan must pay on a monthly basis the total cost of that coverage plus any additional amount permitted by law. Your first payment for continued coverage must be made within 45 days of the date you sign the election form. Your payment must be sufficient to pay the applicable costs retroactive to the day following the event which caused coverage to end.

Benefits under Continued Coverage

Continued coverage will be exactly the same vision coverage you or your dependent would have been entitled to if your employee or their dependent status had not changed. Any future changes in the benefits or cost of coverage for the Plan also will apply to you.

Extended Benefits

Benefits will be payable for covered expenses incurred in connection with vision services and materials which were ordered while the individual was covered under this plan if the item is finally delivered to such individual within 60 days after termination of coverage.

Confidentiality of Information

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in EyeMed's privacy notice, located on their website:

<http://portal.eyemedvisioncare.com/wps/portal/em/eyemed/privacylegal>.

Glossary

Benefit Frequency means the period of time in which a benefit is payable as shown in the Schedule of Benefits. The Benefit Frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

Copayment means the designated amount, if any, shown in the Schedule of Benefits each Insured Person must pay to a Provider before benefits are payable for a covered Vision Examination or Vision Materials per Benefit Frequency.

Comprehensive Eye Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Insured Person means an employee or eligible dependent, if enrolled, who meets the eligibility requirements for the Plan and whose coverage is in force and has not ended.

In-Network Provider means a Provider who has signed a Preferred Provider Agreement with the PPO.

Out-of-Network Provider means a Provider, located within the PPO Service Area, who has not signed a Preferred Provider Agreement with the PPO.

PPO Service Area means the geographical area where the PPO is located.

Preferred Provider Agreement means an agreement between the PPO and a Provider that contains the rates and reimbursement methods for services and supplies provided by such Provider.

Preferred Provider Organization ("PPO") means a network of Providers and retail chain stores within the PPO Service Area that has signed a Preferred Provider Agreement.

Provider means a licensed physician or optometrist who is operating within the scope of their license or a dispensing optician.

Vision Examination means any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

Vision Materials means those materials shown in the Schedule of Benefits.