

UNIVERSITY OF MISSOURI SYSTEM
Vision Benefit Plan

Effective January 1, 2024



This summary plan description (SPD) is designed to provide an overview of the Vision 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](http://umurl.us/CBR) (umurl.us/CBR) or the [HR Service Center](http://umurl.us/HRSC) (umurl.us/HRSC).

In the event there is a conflict of language between the Summary Plan Description and the insurance documents, the language in the insurance documents will control.

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Introduction

The Vision Plan (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 Vision Savings Pass.

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 Vision Service Plan Insurance Company (VSP) providers. The Plan does give allowances when you obtain services and materials from non-network providers.

Unless otherwise stated the rules apply to Retirees and LTD Recipients where Employees are mentioned.

Benefit Summary of Vision Care Services – VSP 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
Retinal Imaging		Up to \$39	N/A
Materials (Includes Frames and Lenses) One copay of \$25 applies when both lenses and frames are purchased*.			
Frames*	Every other calendar year	\$25 copayment (\$140 allowance; \$190 on featured frames)	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
Lined Bifocal Lenses	Once per calendar year	\$25 copayment	Reimbursed up to \$65
Lined Trifocal Lenses	Once per calendar year	\$25 copayment	Reimbursed up to \$85
Standard Progressive Lens	Once per calendar year	\$25 copayment	Reimbursed up to \$65
Polycarbonate lenses are provided for Dependent Children at no additional cost at in network provider locations.			
Lenticular Lenses	Once per calendar year	\$25 copayment	Reimbursed up to \$125
Lens Options Paid by member and added to the base price of lens			
— Premium Progressive Lens — Custom Progressive Lens	Once per calendar year	\$95 - \$105 copayment \$150 - \$175 copayment	Reimbursed up to \$65
UV Protection	Once per calendar year	\$10 - \$17 copayment	N/A

Tint (Solid and Gradient)	Once per calendar year	\$15 - \$17 copayment	N/A
Scratch-Resistant Coating	Once per calendar year	\$17 - \$33 copayment	N/A
Anti-Reflective Coating	Once per calendar year	\$41 - \$85 copayment	N/A
Photochromic Lenses	Once per calendar year	\$75 copayment	N/A
High-index Lenses	Once per calendar year	\$56 - \$60 copayment	N/A
Adult Polycarbonate	Once per calendar year	\$31-35 copayment	N/A
Contact Lenses (in lieu of lenses and frames)			
Contact Lens (fitting and evaluation)	Once per calendar year	Up to \$40	N/A
Contact Lenses — Conventional or Disposable	Once per calendar year	\$140 allowance (copayment does not apply)	Up to \$125
— Medically Necessary		\$25 copayment	Up to \$210
Essential Medical Eye Care			
Retinal Screening for members with diabetes	Available as needed	\$0 copay	N/A
Additional exams and services beyond routine care to treat urgent symptoms or monitor ongoing conditions (see <i>Essential Medical EyeCare</i>)	Available as needed	\$20 per exam	N/A

Low Vision			
All Low Vision services are subject to prior approval by VSP's Optometric Consultants			
Professional services, as necessary, for severe visual problems not correctable with regular lenses.			
Benefit	Frequency	Network	Non-Network
Supplemental Testing (evaluation, diagnosis and prescription of vision aids where indicated)	24-month Benefit Period	Covered in Full*	Up to \$125
Supplemental Aids	24-month Benefit Period	75% of approved amount up to \$1,000	75% of approved amount up to \$1,000 allowance
*Maximum benefit for all low vision services and materials is \$1,000 every two (2) years and a maximum of two supplemental tests within a two-year period.			

Medically Necessary Contact Lenses

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

- Aniridia
- Aphakia
- Nystagmus
- Keratoconus
- Corneal Transplant
- Corneal Dystrophies
- Corneal Neovascularization
- Anisometropia: 3.00 or more diopter difference in prescription between the two eyes
- High Ametropia: greater than or equal to +/- 10.00 diopters in either eye based on the spectacle prescription
- Physical condition of ears or nose which prohibits use of eyeglasses

Essential Medical Eyecare

Essential Medical Eyecare is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the Plan, Eyecare Professionals provide treatment and management of urgent and follow-up services. Primary eyecare also involves management of conditions which require monitoring to prevent future vision loss. Coordination with your medical coverage may apply. See *Coordination of Benefits* section.

Examples of symptoms which may result in you seeking services on an urgent basis may 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

Examples of Conditions which may require management include, but are not limited to:

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

VSP LightCare™

Even if you don't wear prescription glasses, you can use your frame and lens benefit towards ready-made non-prescription glasses or non-prescription blue light filtering glasses, available from your VSP Provider or [Eyeconic.com](https://eyeconic.com)®.

Online Contact Lenses and Eyewear with Eyeconic®

[Eyeconic.com](https://eyeconic.com)® is the VSP online eyewear store where you can conveniently browse and purchase prescription and non-prescription eyewear and choose from the most popular brands of contacts at competitive prices. You can connect to your VSP insurance benefits, upload your prescription at checkout and purchase prescription eyewear or contact lenses after your WellVision Exam. Even if you've already used your benefits for the year, as a VSP member (Vision Insurance Plan or Vision Savings Pass), you will still receive a discount on glasses and sunglasses.

VSP Providers

You can access the University of Missouri network VSP providers at <https://universityofmo.vspforme.com/>. You may also call VSP's Customer Care Division at 800-877-7195 for a provider directory.

Access to Services and Materials

To access services, you call a VSP provider to make an appointment. You will need to let the provider know that you have coverage with VSP and they will then verify your eligibility, plan coverage and obtain authorization prior to your appointment. VSP does not issue identification cards.

Payment for Services

Network Services

When you receive services at a participating VSP 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.

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, less any applicable copayment. Obtaining services from an out-of-network Provider will typically result in higher out of pocket expenses.

A claim must be submitted to VSP within 180 calendar days from the date services are rendered and/or materials provided. In the event it is not reasonably possible to submit claims within this period, claims must be submitted as soon as reasonably possible. However, in no event, except in the absence of legal capacity of the Covered Person, may claims be submitted later than fifteen (15) months from the time services are rendered or materials provided. Claims received by VSP after these stated deadlines will be denied unless prohibited by applicable state or federal law.

To receive your out-of-network reimbursement, you must complete the Request for Reimbursement form and attach your itemized receipts. For your convenience, the form can be completed online by logging into your account at <https://universityofmo.vspforme.com/>. You can also request a paper form by calling VSP's Customer Care Division at 1-800-877-7195.

Benefit Summary – VSP Vision Savings Pass

The Vision Saving Pass is only available to Enrollees and their family if no one in the family is enrolled in the Vision Insurance plan. There is no premium cost to the Vision Savings Pass. To receive the discount, you must visit a VSP provider and reference the plan number: 40151842.

WellVision Exam	Frequency: Once per Calendar Year
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\$50 with purchase of a complete pair of prescription glasses
20% savings without purchase

Retinal Screening	Frequency: Unlimited
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Guaranteed pricing with WellVision Exam, not to exceed \$39

Frame discount*	Frequency: Unlimited
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25% savings when a complete pair of prescription glasses is purchased

Standard Plastic Lenses*	Frequency: Unlimited
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With purchase of complete pair of prescription glasses:

- Single vision \$40
- Lined bifocals \$60
- Lined trifocals \$75

Lens Options*	Frequency: Unlimited
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Average savings is 30% on lens enhancements such as progressive, scratch-resistant and anti-reflective coatings.

Sunglasses	Frequency: Unlimited
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20% savings on non-prescription sunglasses from any VSP doctor within 12 months of your last WellVision Exam.

Contact Lenses	Frequency: Unlimited
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15% savings on contact lens exam (fitting and evaluation)

Laser Vision Correction

Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

*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 a VSP provider.

Exclusions

The following items are not covered by the Vision Insurance Plan or the Vision Savings Pass.

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Orthoptic or vision training and any associated supplemental testing.
- Medical and/or surgical treatment of the eye.
- Replacement of lost or damaged contact lenses, except at normal intervals when services are otherwise available.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Additional office visits associated with contact lens pathology.

- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Surgery, and any pre- or post-operative services, except as an ocular adnexa service included herein.
- Treatment for any pathological conditions.
- An eye exam required as a condition of employment.
- Insulin or any medications or supplies of any type.

Additional Discounts

The below discounts apply to both the VSP Vision Insurance Plan and the VSP Vision Savings Pass

Savings on Laser Vision Correction

VSP offers laser vision correction discounts through contractor laser centers. For additional information, visit www.vsp.com, login and click on “offers”. Once you choose your provider, make sure to tell them you are a VSP member to receive your discount.

Hearing Discount Benefit through TruHearing

TruHearing makes hearing aids affordable by providing exclusive savings to all VSP members. You can save up to 60% on a pair of hearing aids with TruHearing. What’s more, your Dependents and even extended family members are eligible too. For additional information, call **1-877-396-7194**. You and your family members must mention VSP.

Coordination of Benefits

Coordination of Benefits with Medical Plan Administrators

Your Vision Plan has a “coordination of benefits” provision; however, due to the routine vision care benefit, overlap does not occur in most cases with your medical plan. If this should occur, your VSP provider will communicate with the patient’s physician to coordinate benefits available under both the vision and medical plans.

Coordination of Benefits with Non-Medical Plans

If you are coordinating benefits with a non-medical plan, the patient must provide the VSP provider with both covered members’ names and member ID numbers.

Determining Primary and Secondary Coverage

- The Plan that covers the patient as an Employee is primary.
- The Plan that covers the patient as a Dependent is secondary.
- If the patient is a Dependent Child and is covered under both parent’s plans, the parent whose birth date falls first in the calendar year has the primary plan.

Coverage

The primary plan pays as if the secondary plan does not exist. If a VSP plan is the secondary plan, the patient will receive allowances (examination, lenses and frame) that will be used to pay up to, but not more than, the patient’s out-of-pocket expenses.

Options for Duplicate VSP Coverage

When a patient is covered under two VSP plans, the following options for coordinating benefits are applied:

One pair of glasses	When the patient obtains one complete pair of glasses, the VSP benefits can be coordinated to offset plan copayment(s), lens options, and/or frame coverage.
Two pairs of glasses	When the patient obtains two pairs of glasses, the secondary examination amount can be applied toward out-of-pocket expenses on both complete pairs of glasses.

Contact lenses	When the patient receives contact lenses and an eye exam, the exam can be paid using the primary benefit. The contact lens allowances under both plans and a secondary exam amount can be applied toward the contact lenses.
Contact lenses & glasses	When the patient receives a complete pair of glasses and contact lenses, the exam amount available on the secondary benefit can be applied to offset out-of-pocket expenses from the complete pair of glasses and contact lenses.

Coordination of Benefits with Out-of-Network Services

If the patient obtains services from a provider who is not part of the VSP network, the itemized bill should be sent to VSP. VSP will reimburse the eligible patient up to the contracted out-of-network allowed amount, not to exceed the actual charges.

Claims Questions

If you do not understand or agree with the handling of your vision benefit, you should first contact VSP to discuss. If you do not agree with the coverage, you may appeal the decision per the following process:

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of receipt.

Claim Denial Appeals: If, under the terms of the Policy, a claim is denied in whole or in part, a request may be submitted to VSP by Covered Person, or Covered Person's authorized representative, for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal: The request must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, 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 an appeal from the Covered Person.

Second Level Appeal: If the Covered Person disagrees with the response to the initial appeal of the denied claim, the Covered Person has a right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, the Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to the Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies: When Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation. Covered Person may contact the U. S. Department of Labor or the State insurance regulatory agency for details. Covered Persons may also contact the Missouri Department of Insurance, Financial Institutions and Professional Regulation ("DIFP") at any time by calling toll-free to (800) 726-7390, or by writing to Missouri DIFP, Attn: Consumer Affairs, P.O. Box 690, Jefferson City, MO 65102-0690.

Time of Action: No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting their grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable documentation have been filed with VSP. No such action shall be brought after the expiration of three (3) years from the last date that a claim and any applicable invoices were submitted to VSP, and no such action shall be brought at all unless brought within three (3) years from the expiration of the time within which such materials are required to be submitted in accordance with the terms of the Policy.

Complaints and Grievances Procedure

You have the right to expect quality care from VSP Preferred Providers. Complaints and grievances are disagreements regarding access to care, quality of care, treatment, or service. You may submit any complaints and/or grievances, including appeals, in writing to:

VSP
3333 Quality Drive
Rancho Cordova, CA 95670-7985

You can also submit verbally by calling VSP's Customer Care Division at 1-800-877-7195.

VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) calendar days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify you of the expected resolution date. Upon final resolution VSP will notify you of the outcome in writing.

More information is available under "Patient's Rights and Responsibilities" on VSP's web site at www.vsp.com.

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 thirty (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.

Per diem and variable hour Employees are excluded as an Employee under this Plan

Disabled Employee Eligibility (LTD Recipient)

You are eligible for coverage under this Plan if you are an individual who, while covered as an Employee (as defined in University Collected Rules and Regulations CRR 310.020 and CRR 320.050), became totally and permanently disabled in accordance with the University's Long Term Disability Plan and who is entitled to continued service credit (ie. vested) as a Disabled Employee under the University's Retirement, Disability and Death Benefit Plan, or, effective January 1, 2020, who has been a benefit eligible Employee for the five consecutive years immediately preceding the date on which the Employee became totally and permanently disabled. A Disabled Employee is a Long-Term Disability benefit recipient, also known as LTD Recipient.

Retiree Eligibility

If you are a Retired Employee of the University (Retiree), you are eligible for coverage, provided the following conditions are met:

- you were covered under the Plan immediately prior to your retirement; and
- you re-enroll in the Plan when you retire; and
- if you retired on or before December 31, 2017, you were either:
 - age 55 or older with at least ten (10) years of service, or
 - age 60 or older with at least five (5) years of service; or
- if you retire on or after January 1, 2018, you must have been employed in a UM System benefit eligible-position and accumulated at least five years of service, as measured by the University of Missouri Retirement, Disability and Death Benefit Plan, on December 31, 2017, and on your retirement date you must:

- be at least 60 years old; and
- have at least twenty (20) years of service with the UM System.

If you are a Retired Employee, are reemployed by the University after your retirement, and subsequently retire again, special rules apply:

- If, upon your initial retirement from the University, you were eligible to enroll in the Plan, based on your satisfaction of the eligibility requirements above, you will be eligible to reenroll in the Plan upon your retirement following reemployment (even if you did not initially enroll after your initial retirement), provided you still meet all requirements above. For purposes of determining whether you still meet the requirements above upon your retirement following reemployment, your initial date of retirement will determine which eligibility requirements apply. For example, if you initially retired on August 1, 2017, and retired following reemployment on August 1, 2019, you must meet the age and service requirements above for individuals who retired on or before December 31, 2017, not the age and service requirements for individuals who retire on or after January 1, 2018.
- If, upon your initial retirement from the University, you were not eligible to enroll in the Plan, your eligibility to enroll in the Plan upon your retirement following reemployment depends on your reemployment date:
 - If you are reemployed prior to January 1, 2020, and upon your retirement following reemployment you now satisfy the eligibility provisions above, you may enroll in this Plan upon your retirement following reemployment. You must meet the eligibility requirements above applicable to the date of your retirement following reemployment.
 - If you are reemployed on or after January 1, 2020, you may not enroll in this Plan upon your retirement following reemployment, even if you now satisfy the eligibility provisions above.

If you experience a termination from employment, but were not eligible for retirement under the University's Retirement, Disability and Death Benefit Plan, are reemployed by the University, and subsequently separate from employment again, special rules apply:

- If you are reemployed prior to January 1, 2020, and upon your separation following reemployment you satisfy the eligibility provisions above, you may enroll in this Plan upon your separation following reemployment. You must meet the eligibility requirements above applicable to the date of your separation following reemployment.
- If you are reemployed on or after January 1, 2020, you may not enroll in this Plan, upon your separation following reemployment if you did not meet the eligibility requirements above on the date of your initial termination from employment, even if you satisfy the eligibility provisions above at the time of your separation following reemployment.

If you are eligible to reenroll (or enroll for the first time) upon retirement or separation after reemployment, you must enroll in this Plan consistent with the requirements in *Coverage Begin Date, Retirees*.

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 (also commonly known as a Domestic Partner) and Child(ren); each of your natural Children, stepchildren, foster Children, adopted Children, or Children placed in your home for adoption younger than age 26 (note the term "stepchild" does not include the children of your Sponsored Adult Dependent).

Children for whom a court has lawfully appointed the Employee (and/or the Employee's legal Spouse) as a legal guardian (legal guardianship) who is responsible for providing Principal Financial Support provided the:

- Child is unmarried
- Child resides full time with the Employee in a parent-child relationship
- Child is declared a dependent on Employee's federal income tax return, **and**

- Legal guardianship was awarded prior to the Child's 18th birthday and still in effect.
 - Legal guardianship ends on the Child's 18th birthday, unless there is a court order extending the guardianship.

If your unmarried Child is mentally or physically incapable of self-sustaining employment prior to reaching the maximum age and dependent on you or your Spouse for Principal Financial Support, they may be eligible to remain covered by the Plan. See *Coverage for a Disabled Dependent Child* for more information.

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

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.

Coverage for a Disabled Dependent Child

If an enrolled Dependent Child with a mental or physical disability reaches the maximum age when coverage would otherwise end, the Plan will continue to cover the Child, as long as:

- The Child is unmarried;
- The Child is incapable of self-sustaining employment due to a mental or physical disability prior to reaching the maximum age; and
- The Child receives Principal Financial Support from you or your Spouse; and
- You provide application for continuation of dependent status for such a Child and proof of the Child's incapacity and dependency to the University within thirty-one (31) days of the date coverage would have otherwise ended because the Child reached the maximum age, or in the case of a newly benefit-eligible Employee, within thirty-one (31) days of becoming newly eligible; and
- You provide proof, upon the University's request, that the Child continues to meet these conditions.

To be eligible for continuation of Dependent status once the Child has reached the maximum age, the Child must be covered as a Dependent as defined in this Plan on the day immediately preceding the day the Child reaches the maximum age. If you fail to submit proof, coverage shall be discontinued at the end of the month in which the Dependent attains maximum age. In the case of a newly benefit-eligible Employee, if application for Dependent status for such a Child and proof of the Child's status is not submitted within thirty-one (31) days of the Employee adding the Child to their plan, the Dependent will not be eligible for coverage.

The University has the right to require proof of the continuation of disability upon attainment of such age as often as deemed necessary; however, you will not be asked to provide proof for more than once a year. Proof includes:

- Social Security Benefit Verification Letter; or
- Completion of Physician Certification Form

If you do not supply such proof within thirty-one (31) days or being requested, the Plan will no longer pay benefits for that Child. The University reserves the right to request a medical examination at the University's expense.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Premium Payment

As an Enrollee, you pay the full cost of the premium for vision insurance coverage.

If you are an Employee, contributions are deducted from your paycheck. The completed benefits enrollment (via online or paper) is the authorization to the University to deduct the monthly contributions from your salary. If you are on a leave of absence without salary, you are required to make your contribution by cash payment during your leave.

Contributions are not prorated. If your participation begins on any day other than the first day of the month, your monthly contributions will begin on the first day of the month next following the effective date of your participation (i.e., no contributions will be due for the first partial month of participation). Monthly contributions are paid during the month to which the contributions relate.

Monthly contributions for participation shall cease at the end of the month in which you cease work with the University (which is the day immediately preceding your termination date).

Employee contributions 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. For more details about how the before-tax feature works for you, refer to your Flexible Benefits Plan SPD.

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 when your contributions are on a before-tax basis, certain IRS restrictions prohibit enrollment changes during the year unless the changes are in connection with a qualifying family/employment status change.

LTD Recipient premium payments are made on an after-tax basis and billed monthly.

Retiree premium payments are made on an after-tax basis and deducted from your pension check or billed monthly.

Coverage Begin Date

Employees

Coverage begins on the date of hire or the benefit eligibility date provided you submit your completed benefits enrollment (via online or paper) within thirty-one (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 submit your completed benefits enrollment (via online or paper) within thirty-one (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.

LTD Recipients

If you become an LTD Recipient mid-year, you will be eligible to continue the coverage you had as employee. Your coverage will begin upon notice of your disability approval or when disability benefits begin, whichever comes later.

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. Coverage will continue as currently elected provided you were enrolled in the coverage at the time of retirement and submit the New Retiree Benefits Enrollment Form to participate as a Retiree within thirty-one (31) days of retirement. **Please note:** Changes to coverage or new elections may only occur during Retiree Annual Enrollment.

If you elect or change coverage during Retiree Annual Enrollment, your election will become effective on the first of the year following the Retiree Annual Enrollment period.

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 coverage will commence as follows: If your reemployment date is the first of the month, your Employee coverage under this Plan will commence on that date. If your reemployment date is effective any other day of the month, your Employee coverage under this Plan will commence on the first of the month following your rehire date. Your Retiree coverage under this Plan will "freeze" on the day immediately preceding the date in which coverage as an Employee commences. For example, if you are reemployed on October 1 and meet the eligibility requirements as an Employee on October 1, your coverage as an Employee will commence October 1 and your coverage as a Retiree will "freeze" September 30. If you are reemployed on October 1 and do not meet the eligibility requirements as an Employee until November 15 (because, for example, you were not initially in benefit eligible employment), your coverage as an Employee will begin December 1, and your coverage as a Retiree will freeze November 30. 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 definition of Employee under this plan), if you are eligible to enroll in this Plan, you must **immediately enroll in (if you have not previously been eligible to do so) or reinstate Retiree insurance coverage** or you will forfeit your right to participate in this plan as a Retiree at a later date. For more information on eligibility, see *Eligibility for Coverage, Retiree Eligibility*.

Dependents

As an Employee or LTD Recipient, Dependent coverage becomes effective on the date your personal coverage becomes effective, if by then you have completed and submitted the benefits enrollment (via online or paper). If, after your coverage becomes effective, you acquire a new Dependent — by marriage, for example — you have thirty-one (31) days to obtain coverage by submitting a Life Event through the University's self-service portal (myhr.umsystem.edu), including submitting required proof of relationship documentation within thirty-one (31) days after the event occurs.

In the case of an adopted Child or a Child placed in your home for adoption or legal guardianship, you also have thirty-one (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 by completing and submitting a Life Event through the University's self-service portal (myhr.umsystem.edu) within thirty-one (31) days of the event. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

In instances where applications for enrollment are submitted subsequent to thirty-one (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 one hundred eighty (180) days from the date the Child was first eligible. If the enrollment form is submitted after one hundred eighty (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.

As a Retiree, 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 thirty-one (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. Contact the HR Service Center to request the appropriate Retiree change form, which must be completed and returned (including proof of relationship) for such Spouse or Sponsored Adult Dependent and eligible Dependent Children within thirty-one (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

As an Employee or LTD Recipient, 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, or legal guardianship
- 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. It is your responsibility to notify the University of any changes in your family/employment status by completing and submitting a Life Event through the University's self-service portal (myhr.umsystem.edu) within thirty-one (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 thirty-one (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 first of the month following the date of the event, unless the event occurs on the first day of the month, then coverage will become effective on that date.

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 submit a Life Event through the University's self-service portal (myhr.umsystem.edu), including supporting required proof that the other coverage ended for the individual involved within thirty-one (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 submit a Life Event through the University's self-service portal (myhr.umsystem.edu), including supporting required proof that the other coverage ended for the individual involved within thirty-one (31) days after this event occurs.

OR

1. Due to marriage, establishment through University affirmation of a Sponsored Adult Dependent, birth, adoption or placement for adoption, or legal guardianship - 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 by submitting a Life Event through the University's self-service portal (myhr.umsystem.edu), including submitting required proof of relationship documentation.

This is called a special enrollment period. Coverage will be effective on the first of the month following the date of the event, provided your benefits enrollment (via online or paper) is completed and submitted within thirty-one (31) days of the date of the event. In situations of birth, adoption or placement of adoption or legal guardianship, coverage will be effective on the date of the event provided the benefits enrollment is completed and submitted within thirty-one (31) days of the date of the event.

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: Employees and LTD Recipients 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 Enrollee's Death

Employees

If you die while actively employed by the University as an Employee, or as a LTD Recipient, your eligible surviving Spouse or surviving Sponsored Adult Dependent may continue coverage after your death under the Plan available to Retirees, if the following requirements are satisfied:

- Your Spouse must have been married to you at the time of your death, and you must have been married to such Spouse for at least one year preceding your death; and
- Either:
 - at the time of your death, you must have been vested in the University Retirement, Disability and Death Benefit Plan (having completed at least five (5) years of creditable service), or you would have been vested if you were covered by the University of Missouri Retirement, Disability and Death Benefit Plan instead of the Civil Service plan, Federal Employees Retirement plan, or the Missouri State Retirement plan; or

- effective January 1, 2020, at the time of your death, you must have been a benefit eligible Employee for the five (5) consecutive years immediately preceding your death.

Alternatively, your surviving Sponsored Adult Dependent is eligible to continue coverage in this Plan after your death if the above conditions are satisfied, except that in lieu of the marriage requirement above, you must have provided a Sponsored Adult Dependent affidavit to the University at least one year preceding your death.

In addition, the continuation of coverage is available for your Children, but only when your surviving Spouse or surviving sponsored adults coverage is also continued. The continuation of coverage in this Plan, under this provision, is subject to the payment of monthly contributions by your surviving Spouse or surviving Sponsored Adult Dependent. Eligible Children are described under *Eligibility for Coverage, subsection Dependent Eligibility*.

Retirees

If you die after retirement from the University, your eligible surviving Spouse or surviving Sponsored Adult Dependent may continue coverage after your death, as described above, including coverage for your eligible Children. It is important to note, that the coverage for the surviving Spouse or surviving Sponsored Adult Dependent of a Retiree is available only to the person to whom the Retiree was married or had an affidavit of adult sponsored partnership with the University on the date of the Retiree's death and to whom the Retiree was married or had a partnership with at the time of retirement.

No continued coverage in this Plan is available for Children unless there is a surviving Spouse or surviving Sponsored Adult Dependent who is also covered. Refer to the *Continuation of Vision Plan coverage (COBRA)* section for information on continuation of coverage for dependent Children, upon your death, when no surviving Spouse or surviving Sponsored Adult Dependent is covered.

Enrollment for continued coverage must be made within thirty-one (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 the Enrollee's status
- 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 Enrollees 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 Eligible Dependents may continue vision coverage for up to eighteen (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 thirty-six (36) months if their coverage ends for any of the following reasons:

- divorce or legal separation from the Enrollee
- the death of the Enrollee
- 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 thirty-six (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 Enrollee
- 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 twenty-nine (29) months, rather than eighteen (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 eighteen (18) months of continued coverage and within sixty (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 thirty (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 thirty-six (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

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 Spouse or 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 sixty (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 sixty (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 forty-five (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 sixty (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 VSP's Notice of privacy practices, located on their website:

<https://www.vsp.com/legal/privacy>.

Glossary

Blepharitis	Inflammation of the eyelids.
Cataract	A cloudiness of the lens of the eye obstructing vision.
Child or Children	means: <ul style="list-style-type: none">• natural Children; or• stepchildren (note that the child of an Employee's Sponsored Adult Dependent is not a stepchild); or• foster Children (subject to court order or placement by an authorized agency); or• legally adopted Children or Children placed in the Employee's home for adoption (subject to court order); or• each Child, who otherwise meets the definition of "Child" under the Plan, of an Employee for whom the University has received a valid Notice of Order to Enroll and for which the University is obligated to comply under Senate Bill No. 253 which repeals various Sections of RSMO 1986 and RSMO Supp. 1992; or• each Child who a court has lawfully appointed the Employee (and/or the Employee's legal Spouse) as a legal guardian (legal guardianship) who is responsible for providing Principal Financial Support provided the:<ul style="list-style-type: none">○ Child is unmarried,○ Child resides full-time with the Employee in parent-child relationship,○ Child is declared a dependent on the Employee's federal income tax return; and○ legal guardianship was awarded prior to the Child's 18th birthday and is still in effect. <p>Legal guardianship ends on the Child's 18th birthday, unless there is a court order extending the guardianship.</p>
Conjunctiva	The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye.
Conjunctivitis	See Pink Eye.
Coordination of Benefits	Procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement.
Copayments	Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.
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.

Covered Person	An Enrollee or Eligible Dependent who meets the criteria under the <i>Eligibility for Coverage</i> section and on whose behalf premiums have been paid to VSP, and who is covered under the Plan.
Diplopia	The observance by a person of seeing double images of an object.
Disabled Employee	means someone who is a Long-Term Disability benefit recipient, also known as LTD Recipient. See <i>Eligibility for Coverage</i> .
Dependent	See Eligible Dependent.
Domestic Partner	See Sponsored Adult Dependent.
Eligible Dependent	Your Spouse/Sponsored Adult Dependent and/or Child(ren). See <i>Eligibility for Coverage</i> , subsection, <i>Dependent Eligibility</i> .
Enrollee	An Employee, Retiree or LTD Recipient.
Employee	Means 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: <ul style="list-style-type: none"> • You are classified as .75 FTE or more. • You have an appointment duration of at least nine months. • You are regularly scheduled to work an average of thirty (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.
Eyecare Professional	Any duly licensed optometrist (O.D.), ophthalmologist or other doctor of medicine (M.D.), or doctor of osteopathy (D.O.).
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.
GAP Provider	A non-VSP provider that has been authorized by the University of Missouri and VSP to provide Plan Benefits on behalf of Covered Persons of VSP through the University's vision insurance plan. For example, Mason Eye.
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.
In-Network Provider	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 Plan Benefits on behalf of Covered Persons of VSP. Also referred to as VSP Provider.

LTD Recipient	See Disabled Employee.
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. Also known as conjunctivitis.
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 in the <i>Schedule of Benefits</i> section.
Principal Financial Support	means during the calendar year, you are continuously providing more than one half of the total support of the Child, including the amount spent to provide food, lodging, clothing, education, medical, dental and vision care, recreation, transportation and similar necessities.
Out-Of-Network 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 Administrator	The person specifically so designated on the Client application, or if an administrator is not so designated, the Client. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Client.
Policy	The contract between VSP and The Curators of the University of Missouri upon which this Plan is based.
Retinal Nevus	A pigmented birthmark on the sensory membrane lining the eye which receives the image formed by the lens.
Retiree	means you are a Retired Employee of the University (Retiree) and you are eligible for coverage, provided the conditions under <i>Eligibility for Coverage</i> , subsection <i>Retiree</i> , are met.
Schedule of Benefits	Lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.
Sponsored Adult Dependent	Also commonly referred to as a Domestic Partner, means an adult person who meets all of the following criteria: <ul style="list-style-type: none"> • has had a single dedicated relationship of at least twelve (12) months with the Employee;

- has had the same principal residence as you for at least twelve (12) months, and continues to have the same principal 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; and
- has not been determined by a court or physician to be mentally incompetent.

Spouse means the lawful Spouse of an Employee, LTD Recipient or Retiree.

Systemic Condition Any condition of 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.

Urgent Care Services for a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical, action.