# VISION CARE BENEFITS

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IMPORTANT NOTICE: Federal law requires every employer to notify each covered employee and dependent(s) of their continuation of coverage rights after termination of employment. Your rights regarding continuation of coverage can be found on page 5 of this booklet.
INTRODUCTION TO THIS PLAN DESCRIPTION

To Covered Employees:

We are pleased to provide you with this summary description of your Vision Care Benefits. As you read through this booklet, keep in mind that it is intended to be a simple summary of the terms and conditions of benefits covered. Although this booklet describes in general terms the eligibility and coverage under this Vision Care Plan, it is not intended to cover every situation which might occur. Any reference in this booklet to a coverage or coverages not shown in the Benefits Coverage Schedule(s) shall not be applicable. The terms and conditions for eligibility and coverage are contained within this document and in the Coverage Schedule of Benefits located in the front of this booklet.

Provide further that under and subject to the terms and conditions of this Plan that the Employee and his/her dependent(s), if any, whose name appears on the enrollment request and is recorded with the Plan Administrator, is eligible for the coverage requested. Once all Plan provisions relating to eligibility and effective date of coverage have been fulfilled, the employee and dependents will be covered on the effective date set forth in the enrollment request in accordance with the Coverage Schedule contained herein, provided he/she is actively at work on the proposed effective date, otherwise on the date he/she returns to active work.

The provisions set forth on the following pages hereof are hereby made a part of this Booklet.

You should read this material carefully and keep it for reference. It will help you to understand how the Plan works, what rights and benefits are provided for you and your family and how to obtain those benefits.

This Plan is being administered on our behalf by:

Michigan Employee Benefit Services, Inc.
3809 Lake Eastbrook Boulevard
Grand Rapids, Michigan 49546
www.mebs.com
IMPORTANT DEFINITIONS AND TERMS

The following definitions will better help you understand this booklet's provisions.

Allowable Expense: Any necessary, reasonable, and customary item of expense that is at least partly covered under at least one of the Plan's coverage schedules covering the person for whom a benefit request is made.

When a Plan provides benefits in the form of services rather than cash, the value of each service rendered will be considered to be both an Allowable Expense and a benefit paid.

Actively at Work Requirement: A Member/Employee must be on the job and physically able (other than absences due to a medical condition or medical treatment) to perform his/her regular full time duties for a regularly scheduled workday.

Dependent: An employee Member's spouse while not divorced or legally separated from the employee Member; and each of the employee Member's unmarried children who can be declared as a dependent on the employee Member's federal tax returns under the Internal Revenue Code of the United States. Eligibility for continuation of coverage for a divorced or legally separated spouse is further provided and defined in Section GENERAL INFORMATION of this document. Dependent eligibility and limiting age of dependents is defined in Section CONTINUATION OF COVERAGE. An employee Member's children shall include stepchildren, legally adopted children, and any other children receiving coverage pursuant to a Qualified Medical Child Support Order.

Employee: An individual employed by the employer. An independent contractor is not considered an Employee.

Employer: When the term "Employer" is used it means the Waterford School District who is providing this Vision Care Coverage as outlined on the "Benefits Coverage Schedule".

Other Plan: Any plan provided by any employer or any other plan required by law that provides vision care benefits or services under:

A. Group coverage or any other covered or uncovered arrangement of coverage for which any employer contributes all or part of the cost, and/or make payroll deductions; or

B. Basic automobile reparations (no-fault) coverage, but only to the extent of the benefits required by, or available under the applicable no-fault law, and if such no-fault coverage does not, under its rules, determine its benefits after the benefits of any group health, dental, and/or vision coverage.

Benefits payable under another Plan include the benefits that would have been payable if a benefit request had been made for them.

Reasonable Fees: The term "reasonable fee", "charge", etc., shall mean the usual charge made by the provider for a like service in the absence of coverage, but not more than the prevailing charges, as determined by the Plan Administrator, for vision care of a comparable nature, made by providers of similar training and experience, within the area in which the service is actually provided. "Area" means the municipality (or in the case of a large city, the subdivision thereof) in which the service is actually provided or such greater area as is necessary to obtain a representative cross section of charges for a like service.

This Plan: This Waterford School District Vision Care Benefits plan, Group #2.

UC&R: Usual, Customary and Reasonable; see "Reasonable Fees" above.
GENERAL INFORMATION

WHO IS ELIGIBLE FOR COVERAGE

Initial Employee Eligibility

(a) In cases where the Employer pays the full cost of coverage (non-contributory), an employee shall be eligible for coverage under the Plan provided he/she meets all of the following conditions:

(i) The Plan is in effect for the Employer; and
(ii) The employee is included in a class of employees which is eligible for coverage under the Plan; and
(iii) The employee is "Actively At Work" and meets any applicable minimum hours per week requirement; and
(iv) The employee has satisfied the applicable Service Requirement.

Coverage will be effective only when all of the above requirements have been met. For example, if an employee meets requirements (i), (ii), and (iv) he/she will not be covered under the Plan until he/she is Actively At Work (meets requirement (iii)).

(b) In cases where the employee contributes toward the cost of coverage, an employee shall be eligible for coverage under the Plan provided he/she has met all of the requirements in paragraph (a) above (subparagraphs i, ii, iii, and iv), and he/she has completed an enrollment form and authorized his/her employer in writing to deduct the required contribution amount from his/her payroll checks.

Employees who do not complete a written enrollment and authorization for payroll deduction within thirty-one (31) days after the date of initial eligibility (as defined in paragraph (a) above) may not enroll for coverage in the Plan until the following Open Enrollment or Open Enrollments Periods thereafter.

Dependent Eligibility

(a) All eligible employees may enroll their eligible dependents (defined in Important Definitions and Terms Section) in this Plan. The effective date of coverage shall be: 1). The date the employee/subscriber becomes covered under the plan if the dependent is properly enrolled, 2). At subsequent Open Enrollment Periods, 3). The date a dependent becomes an eligible dependent, if enrolled within 31 days of the event. If an application is submitted at any other time, coverage will be effective on the first day of the month following approval of the application and each eligible dependent will be subject to the pre-existing condition provisions of this Plan.

(b) An employee's Dependent Child(ren) can be covered beyond the end of the calendar year of the Dependent Child's nineteenth (19th) birthday provided such coverage is indicated in the Schedule of Benefits located in the front of this booklet. If not limited, coverage for Dependent Children can be continued up to the end of the calendar year of their twenty-fifth (25) birthday, provided all of the following conditions are met:

(i) they are unmarried; and
(ii) they are dependent upon the employee for more than half of their support; and
(iii) they are a member of the employee's household; and
(iv) they are related to the employee by blood, marriage or legal adoption/guardianship; and
(v) all required monthly contributions are made timely on their behalf.

(c) Unmarried children beyond the end of the calendar year of their nineteenth (19) or twenty-fifth (25) birthday (if covered under this plan at the end of the calendar year of their nineteenth [19] or twenty-fifth [25] birthday and continuously thereafter), who are mentally retarded or physically handicapped, dependent on you for a majority of their support, and who are incapable of self-sustaining employment by reason of their mental retardation or physical handicap. (Under no circumstances will mental illness be considered a cause of incapacity nor will it be considered as a basis for continued coverage.)

WHEN COVERAGE IS EFFECTIVE

Effective Date of Coverage

An employee's effective date of coverage will be the first day all applicable conditions in the preceding section have been met.

Any eligible services provided a covered employee prior to the Plan's effective date will not be considered a covered benefit under this Plan.

IMPORTANT NOTE: Employees must submit a completed enrollment form to the Employer within thirty-one (31) days of initial eligibility date for coverage. Prior to the payment of any claims, a completed enrollment form must be submitted to the Benefit Administrator. Contact your Benefit Office for proper enrollment forms.

Change(s) In Coverage/Open Enrollment

Employees may enroll and/or make subscriber changes (such as adding Dependents) during Open Enrollment, or at certain other times subject to the following conditions:

(a) If an Employee member declines enrollment for himself or his dependents (including his spouse) because of other insurance coverage, he may in the future enroll himself and/or his dependents in this plan, prior to the next open enrollment, provided that he complete a written enrollment and loss of coverage document within 30 days after the other insurance coverage ends. In addition, if an Employee member has a new dependent as a result of marriage, birth, adoption, or placement for adoption, he may in the future enroll himself and/or his dependents in this plan, prior to the next open enrollment, provided that he complete a written enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

(b) Employees who are required to contribute toward the cost of their coverage, and who have not completed enrollment and written authorization for payroll deduction within thirty-one (31) days after they initially become eligible for coverage, may enroll at the next Open Enrollment or succeeding Open Enrollments, with coverage to begin effective on the first day of the month following the Open Enrollment, unless they are entitled to enroll earlier due to family status changes as described in paragraph (a) above.

The Open Enrollment Period for your group is indicated on the Benefit Coverage Schedule located at the
When Coverage Terminates

Termination of Coverage
Once an employee is initially eligible for coverage under the Plan, his/her coverage will continue until it is terminated. Termination of coverage will be effective on the first occurring of any of the following dates:

(a) On the first day of the month for which the Employer's contributions are no longer current; provided that coverage shall be reinstated effective the first of the month for which contributions on the employee's behalf resume provided all other eligibility requirements are met; or,

(b) On the first day of the month for which the employee's contributions (if applicable) are not current; provided that coverage may be reinstated at the next following Open Enrollment on payment of required contributions thirty (30) days in advance (and provided all other eligibility requirements are met); or,

(c) At the end of the day on which the employee ceases to be an eligible employee in the class for coverage because of termination of employment or for any other reason; or,

(d) At the end of the day on which the class of employees to which the employee belongs is no longer eligible for coverage; or,

(e) The date on which the Plan terminates.

(f) Dependent coverage will never extend beyond the termination date of the employee's coverage termination date.

Continuation of Group Coverage
This Section should be read carefully by the employee and all eligible covered dependents:

Your coverage will end when you and your dependents are no longer eligible to receive Plan benefits through your Employer. However, under the requirement of a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, the Plan makes available to you and your covered dependents the opportunity for a temporary extension of your coverage in certain instances where coverage would otherwise end. To continue this coverage (called Continuation Coverage), you or the affected dependents will be required to pay the entire applicable Continuation Coverage cost.

The following outlines when you and/or your dependents become eligible for Continuation Coverage:

(a) If you are a covered employee, you have the right to choose Continuation Coverage if your coverage under this Plan ends because of the termination of your employment, a reduction in your hours of employment, layoff, disability, medical leave, or retirement.

(b) If you are the spouse of a covered employee and are covered under the Plan, you have the right to choose Continuation Coverage for yourself if you lose coverage under the Plan for any of the following reasons:
(i) The death of your spouse who is a covered employee; or,
(ii) A termination of your spouse's employment, reduction in your spouse's hours of employment, layoff, disability, medical leave of absence or retirement; or,
(iii) Divorce or legal separation from your spouse; or
(iv) Your spouse becomes entitled to Medicare and his/her coverage under this Plan terminates.

(c) If you are a dependent child of a covered employee and are covered under the Plan, you have the right to Continuation Coverage if you lose coverage under the Plan for any of the following reasons:
(i) The death of a parent who is a covered employee; or,
(ii) The termination of your parent's employment, reduction in your parent's hours of employment with a contributing employer, layoff, disability, medical leave of absence or retirement; or,
(iii) Your parent's divorce or legal separation; or,
(iv) Your parent becomes entitled to Medicare and your parent's coverage under the Plan terminates; or,
(v) You cease to be a "dependent child" as defined under this Plan.

(d) Newborn or Adopted Child
If you have a newborn child or have a child placed with you for adoption (for whom you have financial responsibilities) while your COBRA continuation coverage is in effect, you may add this child to your coverage by notifying the Fund Office in writing within 30 days after the birth or placement. A child born or placed for adoption while you are on COBRA will have the same COBRA rights as your spouse or dependents who were covered by the plan before the event that triggered COBRA coverage. Like all qualified beneficiaries with COBRA coverage, their continued coverage depends on the timely and uninterrupted payment of COBRA premiums.

(e) How Does the Election Take Place? In order to qualify for Continuation Coverage, the employee or a covered dependent has the responsibility to inform the Benefit Office (at the address found in the Introduction to this booklet) immediately after:
(i) a divorce, legal separation, from the Employee member
(ii) a Social Security Administration determination that any qualified beneficiary was disabled at the time of the Employee's termination or reduction in hours, or became disabled at any time during the first 60 days of COBRA continuation coverage, or
(iii) a child losing dependent status under the Plan.

If you do not report one of these events to the Benefit Office within sixty (60) days after the event occurs, Continuation Coverage will not be available. In addition, the Benefit Office should be notified as soon as possible after an Employee's death, termination of employment, reduction in hours, layoff, strike, disability, medical leave of absence, retirement, or entitlement to Medicare.

If an employee, spouse, or dependent is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time of one of the events listed above (or within 60 days thereafter) the Benefit Office must be notified of such determination within 60 days after the determination; in addition, the benefit office must be notified within 30 days of a determination that the employee, spouse, or dependent is no longer disabled.

When notice of a qualifying event has been given as described above, notice of the right to elect
continuation coverage will be provided to the appropriate parties. Notification to a spouse is treated as notification of all other eligible covered Members (dependents) living with the spouse.

If you do not choose Continuation Coverage within the sixty (60) day time limit, your group coverage under the Plan will not be continued.

If you choose Continuation Coverage, the Plan will give you group coverage which, at the time coverage is being provided, is identical (but not including term life insurance, etc.) to the coverage provided under the Plan to similarly situated covered employees and their dependents.

(f) What is the Cost? You and/or your dependents must pay the entire cost of Continuation Coverage at group rates. The cost will not exceed 102% of the cost for providing benefits to individuals in the same benefits selection situation as yourself. If the Social Security Administration determines that you were disabled at the time of termination or reduction of hours and you elect to continue coverage beyond the 18 month period, you may be charged an additional 50% surcharge beginning on the 19th month of coverage. Specific cost information will be provided to you when you become eligible for Continuation Coverage.

(g) How Long Does Continuation Coverage Last? Employee members and Dependents will be afforded the opportunity to continue coverage for thirty-six (36) months after the event which caused Continuation Coverage eligibility. However, if loss of group coverage is due to termination of the Employee’s employment, a reduction in hours, layoff, strike, medical leave of absence, disability or retirement, the Continuation Coverage period is eighteen (18) months for the Employee Member and his eligible dependents.

The 18 month coverage period can be extended to 29 months under the following conditions: if the Social Security Administration determines that the Employee member or an eligible Dependent was disabled at the time of termination of the Employee’s employment, reduction in hours, layoff, strike, medical leave of absence, disability or retirement, or within 60 days of that date, and the Benefit Office is notified in writing within 60 days after the date of the Social Security determination and before the end of the 18 month period, the continuation coverage may be extended up to a total of 29 months from the date of initial continuation coverage, or until the date of determination by the Social Security Administration that the Employee member or covered Dependent is no longer disabled. The Benefit Office must be notified within 30 days of a determination that an Employee member or covered Dependent who was determined to be disabled by the Social Security Administration is no longer disabled.

If you, as a spouse or dependent, are receiving Continuation Coverage for the eighteen (18) month period and another qualifying event occurs, e.g., divorce, legal separation, death, loss of dependent status, you are eligible to have your coverage extended to a total of thirty-six (36) months from the date of the first event qualifying you for Continuation Coverage. If, you as an Employee member, become entitled to Medicare while still actively employed, your Dependent spouse and child(ren) are eligible for COBRA continuation for no less than 36 months from the date of your entitlement to Medicare if a subsequent qualifying event occurs, such as termination of employment.

Regardless of which continuation period applies, an individual’s Continuation Coverage may be cut short for any of the following four reasons:

(i) This Plan no longer provides group coverage;
(ii) You do not pay your contributions for Continuation Coverage on time (You will have a grace period of at least 30 days to pay the monthly COBRA payment, except for the first monthly payment, for which you will have a one-time-only 45 day grace period);

(iii) You or an eligible dependent become covered, after your COBRA continuation coverage begins, under another employer sponsored group plan as an employee, dependent or spouse, provided that continuation will not end for an individual for so long as the coverage under another employer sponsored group plan has an exclusion or limitation with respect to any pre-existing condition of that individual which is covered under this Plan; (if you are or become covered under another group health plan, you must notify the Benefit Office immediately; or

(iv) You or an eligible dependent becomes entitled to Medicare.

Disability After COBRA Continuation Coverage Begins
If the Social Security Administration determines that you (or a member of your family who is also eligible for COBRA continuation coverage) were totally and permanently disabled on the day you lost eligibility for health coverage under the Plan as an active employee, or within 60 days after that, you or your disabled family member may elect to keep COBRA coverage for 29 months.

You or your disabled family member must notify the Benefit Office, in writing, of the Social Security disability determination within sixty (60) days of the date it is issued, and before the end of the initial COBRA coverage period. You or your disabled family member must also notify the Fund Office within thirty (30) days of the date of any final determination by the Social Security Administration that you or your family member are no longer disabled. As with all COBRA coverage, eligibility for this extension depends on the timely and uninterrupted payment of premiums. If your dependents have COBRA coverage extending past 29 months (i.e., 36 months maximum coverage is granted certain qualifying events), then no further extension will be granted because of disability.

Group Conversion of Coverage: Continuation Coverage is not the same as Conversion of Coverage. This group Vision Plan does not include provisions for conversion of coverage.

If you have any additional questions regarding Continuation Coverage, please contact the Benefit Administrator. Also, if you have changed marital status, you or your spouse has changed address, or you have acquired a new eligible dependent, please notify your Employer and the Benefit Administrator.
BENEFIT SERVICES

LIST OF ELIGIBLE VISION SERVICES

A. A Complete Vision Examination
B. Single Vision Prescription, per pair of lenses
C. Bifocal Prescription, per pair of lenses
D. Trifocal Prescription, per pair of lenses
E. Lenticular Prescription, per pair of lenses
F. Frames, per standard set
G. Contact Lens Prescription, per pair of lenses

FREQUENCY OF BENEFIT SERVICE

Frequency of benefit services for a vision examination, lenses, and frames are as indicated in the Benefit Coverage Schedule located at the front of this booklet.

ELIGIBLE AND EXCLUDED CHARGES

ELIGIBLE CHARGES

These are the charges, subject to any limitations or exceptions provided in this coverage, actually made to the employee for the following listed treatments or services to the extent that such charges are usual and customary for the services performed or the materials furnished.

A. A complete vision examination up to but not exceeding the Complete Vision Examination Maximum shown in the Benefit Coverage Schedule. A complete vision examination provides refraction and eye examination including case history, examination for disease or pathological abnormalities of the eyes and lids, ranges of clear single vision and balance and coordination of muscles for far seeing, near seeing and special working distance analysis, and professional consultation;

B. A single vision prescription up to but not exceeding the Single Vision Prescription Maximum shown in the Benefit Coverage Schedule (each pair of lenses);

C. A bifocal prescription up to but not exceeding the Bifocal Prescription Maximum shown in the Benefit Coverage Schedule (each pair of lenses);

D. A trifocal prescription up to but not exceeding the Trifocal Prescription Maximum shown in the Benefit Coverage Schedule (each pair of lenses);

E. A lenticular prescription up to but not exceeding the Lenticular Prescription Maximum shown in the Benefit Coverage Schedule (each pair of lenses); and
F. A frame prescription up to but not exceeding the Frame Prescription Maximum shown in the Benefit Coverage Schedule (per standard set); and

G. A contact lens prescription up to but not exceeding the Contact Lens Prescription Maximum shown in the Benefit Coverage Schedule (each pair of lenses) after cataract surgery or when visual acuity is not correctable to 20/70 in the better eye except by their use. In all other cases, if contact lenses are chosen in lieu of the glasses available under this program, expenses incurred up to the Contact Lens Prescription Maximum shown in the Benefit Coverage Schedule will be payable for the examination fee and materials.

EXCLUDED CHARGES

Vision Care Benefits are not payable and coverage is not provided for:

A. Treatment or services due to disease which is covered by a Workers’ Compensation or Occupational Disease Law, or due to injury arising out of or in the course of any employment by the Employer or for which the individual is entitled to benefits under any Workers’ Compensation Law;

B. Duplication or replacement of lenses or frames which have been lost, stolen or broken (except at normal intervals when the individual would otherwise be eligible for the service or materials);

C. More than one complete examination during any one Benefit Service Frequency period;

D. More than two lenses during any one Benefit Service Frequency period;

E. More than one set of frames during any one Benefit Service Frequency period;

F. Any eye examination required by an employer as a condition of employment;

G. Orthoptics, vision training, subnormal vision aids, Aniseikonia lenses, or non-prescription lenses;

H. Tinted lenses (other than Pink #1 or #2 or light photochromatic lenses);

I. The extra cost of cosmetic lens characteristics as, but not limited to, blended lenses, oversize lenses, coated lenses, and/or progressive lenses;

J. Medical or surgical treatment of the eyes, including Radial Keratotomy, PRK, and Lasik;

K. Services/supplies for which the covered person is not required to pay;

L. Treatment of a condition caused by military action, or war, declared or undeclared;

M. Charges for completion of claim forms or for missed appointments;

N. Services received or ordered before the effective date or lenses and frames ordered while covered but delivered more than 60 days after termination of coverage.

O. Charges for services which do not meet accepted standards of ophthalmic practice, including charges for any such services or supplies which are experimental or research in nature; and
P. The portion of any charge for any service in excess of the reasonable fee.

CLAIM PROVISIONS

GENERAL PROVISIONS
These provisions apply to each coverage under this Plan which contains a specific provision subjecting the payment of benefits under the coverage to the Plan's Claim Provisions.

Written proof of loss under a coverage upon which claim may be based must be furnished to the Plan Administrator on an approved claim form within ninety days after:

A. The end of each month or lesser period for which the Employer is liable for coverage, if coverage provides for the payment at such periodic intervals;

B. The end of each Benefit Determination Period for which the Employer is liable, if coverage is one under which payment is made for charges incurred during a "Benefit Determination Period" as defined in the Benefit Coverage Schedule, and

C. The date of the loss, in case of any other coverage.

Failure to furnish such proof within the required time shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

All benefits will be paid upon receipt of written proof covering the occurrence, character and extent of the event for which claim is made; except that if any coverage provides for payment at monthly or at more frequent intervals, the Plan shall not be required to make payment of benefits thereunder more often than so provided.

The Plan Administrator shall have the right and opportunity to examine the person whose sickness or injury is the basis of the claim when and so often as it may reasonably be required during pendency of the claim.

No action at law or in equity shall be brought to recover under the Plan prior to the expiration of sixty days after written proof of the loss upon which claim is based has been furnished above. No such action shall be brought more than three years after the expiration of the time within proof of such loss is required.

COORDINATION OF BENEFITS

BENEFIT DETERMINATION
In computing the benefits payable under this Plan, the benefits from Other Plan will be taken into account. The term "Other Plan" is defined in the Section Important Terms. This Coordination of Benefits may require a reduction in benefits under this Plan, so that the combined benefits of this Plan and the Other Plan will not be more than the allowable usual, customary, and reasonable charge.

COMPUTATION OF BENEFITS
This Plan will always either pay its regular benefits in full, or it will pay a reduced amount which, when added to the benefits payable and the cash value of any services provided by the Other Plan(s), will equal
100% of the allowable expenses incurred by the covered Member for whom a claim is being filed.

ORDER OF BENEFIT DETERMINATION

If a covered Member is eligible to receive benefits under this Plan, and is eligible at the same time to receive similar benefits under any Other Plan, payment of benefits will be made according to the following order:

(a) Benefits of any Other Plan which does not contain a provision for coordination with other plans are determined prior to determination of any benefits of this Plan.

(b) Primary liability rests with the plan under which the covered Member is eligible as a covered employee. Secondary liability rests with the plan under which the covered Member is eligible as a dependent. In situations where the covered Member is the employee and also is covered as an employee by an Other Plan (as defined in Section 1.22), the Order of Benefit Determination will be those rules as outlined in subsections (d) and (e).

(c) When neither (a), nor (b) is determinative, primary coverage for a dependent child is with the plan covering the parent whose birthday occurs earlier in the calendar year. If both parents have the same birthday, the benefits of the plan, which has the covered Member claiming benefits longer, are determined before those of the plan which covered the covered Member for a shorter period of time. If the Other Plan does not have this rule coordination is determined under the rules of the Other Plan. However, when the parents of a dependent child are legally separated or divorced, the following order of benefit determination applies: the Plan covering the child as a dependent of a parent who has been given financial responsibility for medical, dental, or other health care expenses of the child under a court order of decree is primary. Otherwise, the plan covering the custodial parent will be primary; where the custodial parent has remarried, coverage of the custodial parent will be primary, followed by the plan covering the child as a dependent of the custodial parent's spouse, followed by the plan of the non-custodial parent.

(d) The Benefits of a plan which covers a Covered Member as an employee who is neither laid off nor retired (or as that employed Member's Dependent) are determined before those of a plan which covers that Covered Member as a laid off or retired employed Member (or as that Member's Dependent). If the Other Plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(e) If the above rules do not establish an order of benefit determination, primary liability rests with the plan which has covered the Covered Member or Dependent continuously for the longer period of time.

(f) Where a Covered Member is subject to certain cost containment provisions under the primary plan, any cost containment sanction(s) imposed by the primary plan will not be payable as a benefit, or a secondary balance, by any of the other secondary plan(s).

STANDARD, INTERNAL, AND EXTERNAL COORDINATION OF BENEFITS: If a dependent spouse or child who is also covered as an employee under this Plan and is not considered a dependent, the Coordinations of Benefits provision is External. Should a dependent spouse or child who is also covered as an employee, and is also considered a dependent under the Plan, and standard Coordination of Benefits provisions are applied, the plan is Standard. Should a dependent spouse or child who is also covered as an employee, and is also considered a dependent under the Plan, and benefits are coordinated under a single contract, the plan is Internal. Refer to the Schedule of Benefits.
ADDITIONAL PLAN INFORMATION

Appeal of Denied Claim or Adverse Benefit Determination

Timing of Initial Notice of Benefit Determination by Plan

Urgent Care

MEBS will provide a response to the claimant not more than 72 hours after the receipt of the claim. If the claim is incomplete, MEBS will notify the claimant within 24 hours after the receipt of the claim. The claimant will then have 48 hours to provide the missing information. MEBS will have 48 hours to make a decision after the earlier of its receipt of the missing information or the end of the period for the claimant to provide the missing information.

Concurrent Care

Any termination of an ongoing course of treatment shall be treated as an adverse benefit decision. MEBS will notify the person affected in the form of a notice of adverse benefit determination sufficiently in advance of the termination to allow time for the person to appeal before the benefit is terminated.

Pre-Service Claims (Non-Urgent)

MEBS will provide a benefit determination up to 15 days after receipt of the claim. This period of time may be extended an additional 15 days by MEBS if, for reasons beyond its control, a determination cannot be made within the first 15 days, and MEBS will notify the claimant of this within the first 15 day period, including the reason for the extension. If the reason is that the claim is missing information, the claimant has 45 days from the date of this notice to provide the missing information.

Post-Service Claims

MEBS will provide a benefit determinate no later than 30 days after MEBS receipt of the claim. This period of time may be extended by an additional 15 days by MEBS if, for some reason beyond its control, a determination cannot be made within the first 30 days, and MEBS will notify the claimant of this within the first 30 days including the reason for the extension. If the claim is incomplete, the claimant has 45 days from the date of the notice to provide the missing information.

Notice of Adverse Benefit Determination

Adverse benefit determinations are anything other than granting and paying for the benefit.

Appeal by Claimant

The claimant has 180 days following receipt of the notification to appeal an adverse benefit determination on his claim. The claimant can appeal through his representative. The decision-maker on appeal will not give any deference to the initial adverse determination and, where a medical decision is involved, will rely on health care professional(s) with expertise in the field in question who will not be the same person(s) who made the determination on the initial claim. A claimant who appeals will be allowed the opportunity to submit written comments, documents, records and other information relating to the claim. MEBS will provide reasonable
access to and copies of all documents, records and other information relevant to the application.

**Plan Response to Appeals**

Urgent Claims - *MEBS will respond not later than 72 hours after receiving the appeal.*

Pre-Service Claims - *MEBS will respond not later than 15 days after receiving the appeal.*

Post-Service Claims - *MEBS will respond not later than 30 days after receiving the appeal.*

**WORKERS’ COMPENSATION**

This Plan does not take the place of or affect any requirement for coverage by Workers' Compensation Insurance.

**RIGHT OF RECOVERY**

If an overpayment is made due to any reason, including but not limited to payment under any workers' disability or occupational disease act or law, clerical error or misstatement of fact, the Plan shall have the right to recover such overpayment from the covered employee (or a beneficiary of the covered member's estate), or to deduct such amount of overpayment from future benefits. This provision shall be in addition to, and not in lieu of, any other remedy available to the Plan at law or in equity.

**SUBROGATION**

If an employee incurs expenses on account of bodily injury or sickness, caused by negligence or wrong of a third party, and benefits are payable under this Plan, the employee will receive the benefits, provided that, if there is recovery by the employee or any dependents or a personal representative from the third party, or his/her personal representative, whether by judgment, settlement or otherwise, on account of such bodily injury or sickness, the employee shall reimburse the Plan to the extent of the total amount of such benefits paid under this Plan, but not in an amount in excess of the proceeds of any such recovery after the deduction of reasonable and necessary expenditures, including attorney's fees, incurred in effecting such recovery.

**REASONABLE FEES**

This Plan does not pay the portion of any charge for any service in excess of the reasonable and customary vision charge. The reasonable fee is the usual charge made by the provider for a like service in the absence of coverage, but not more than the prevailing charges, as determined by the Plan Administrator, for vision care of a comparable nature, made by providers of similar training and experience, within the area in which the service is actually provided. "Area" means the municipality (or in the case of a large city, the subdivision thereof) in which the service is actually provided. "Area" means the municipality (or in the case of a large city, the subdivision thereof) in which the service is actually provided.

**RELEASE OF INFORMATION**

Each eligible employee/subscriber covered under this Plan hereby authorizes physicians, hospitals, and other providers of service to furnish the Plan’s designee, Michigan Employee Benefit Services, Inc. (MEBS), upon request, information relating to services which the covered family member is or may be entitled to coverage for under this Plan.
Physicians, hospitals and other providers of services are hereby authorized to permit MEBS to examine their records with respect to such services. All information related to treatment of an eligible family member will remain confidential and shall be used solely for the purpose of determining rights and liabilities arising under this Plan.

ASSIGNMENT LIMITATIONS

This Plan's coverage is "Assignble", no responsibility for the validity or sufficiency of any assignment is assumed by the Employer or the Benefit Administrator. The Benefit Administrator shall not be considered to have knowledge of any assignment unless the original or a duplicate is filed with the Benefit Administrator.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Under federal law, the Plan must recognize a qualified medical child support order (QMCSO) mandating continuation of health care coverage for certain dependent children. A QMCSO is a court order which recognizes the right of an alternate recipient (child) to receive benefits under the Plan. A QMCSO may not require the Plan to provide a type or form of benefit not otherwise provided to children of eligible Employee members. A QMCSO is usually issued in a divorce where an Employee member or his former spouse is ordered by the court to continue to provide medical support for their child or children. When the Plan Administrator receives an order that may include a QMCSO, it will review the order and make a determination as to the order's qualified status. The eligible Employee and possible alternate recipient will then be notified by the Plan Administrator of the determination. Payment of benefits made pursuant to a QMCSO may be made to the alternate recipient's custodial parent or legal guardian.

NOT A CONTRACT OF EMPLOYMENT

Nothing contained in the Plan or this summary plan description shall be construed as a contract of employment between the Employer and any person, nor does the Plan give any person the right to be retained as an employee.

FAVORABLE RESULT OF TREATMENT

Benefits will be considered only for treatment that the Plan Administrator determines has a reasonably favorable prognosis.

PLAN ADMINISTRATION

GENERAL INFORMATION

The Employer has established this Plan exclusively to provide vision care and other related benefits to its eligible employees and their families. The Plan is established, funded, maintained, and sponsored by the Employer. The Employer has contracted with Michigan Employee Benefit Services, Incorporated (MEBS), to provide billing, benefit, and claims administration services. The following is important information concerning this Plan:

(a) **Name of Plan:** The name of this Plan can be found in the Employer Data Schedule located at the front of this booklet.

(b) **Plan Sponsor and Fiduciary:**
The Employer as indicated on the Employer Data Schedule is the Plan Sponsor and Fiduciary of this Vision Care Benefits Plan.

(c) **Plan and Benefit Administrator:**

The Employer has contracted with Michigan Employee Benefit Services, Incorporated (MEBS), for benefit and claims administration services. Any questions about benefits may be directed to MEBS at the following location:

Michigan Employee Benefit Services, Inc. (MEBS)
3809 Lake Eastbrook Boulevard
Grand Rapids, Michigan 49546
www.mebs.com
Telephone number: (800) 968-6327
custserv@mebs.com

The Benefit Administrator:

(i) Does not guarantee or warrant this as an insured plan. The Employer assumes all responsibilities for insuring benefits on behalf of employees covered by the plan(s).

(ii) Does not insure, reinsure, or fund this benefit plan. Should the Plan Sponsor elect not to reinsure this plan, and ultimately not pay (fund) benefit expenses which are eligible for payment under the plan for any reason, the employees covered by the plan may be liable for those expenses.

(iii) Merely processes claims and does not insure the eligible expenses of the Plan. The Administrator does not guarantee employees covered under the plan that eligible expenses will be paid.

(iv) Will promptly process complete claim submissions for benefits made by employees covered by the plan. In the event there are delays in processing claims, the employees covered by this plan shall have no greater rights to interest or other remedies against the Benefit Administrator than as otherwise afforded by law.

(d) **Federal Identification Number:**

This Plan has been assigned an employer identification number by the Internal Revenue Service which can be found on the Employer Data Schedule located at the front of this booklet.

(e) **Plan Year:**

The Plan’s fiscal records are maintained on a plan year basis. The Plan Year is indicated on the Employer Data Schedule.

(f) **Agent for Service of Legal Process:**

The agent for service of legal process can be found at the front of this booklet in the Employer Data Schedule.

**SOURCE OF CONTRIBUTION**

This Plan is funded by the Employer and is established and maintained for the sole purpose of providing benefits to eligible employees and their eligible dependents. Should the Plan ultimately not pay benefit expenses which are eligible for payment under this Plan for any reason, the employees covered by this plan may be liable for those expenses.
expenses.

LEGAL ACTION

No action at law or in equity shall be brought to recover under the Plan prior to the expiration of sixty (60) days after written proof of the loss upon which claim is based has been furnished above. No such action shall be brought more than three (3) years after the expiration of the time within proof of such loss is required or within three (3) years after the filing of a claim, if earlier.

QUESTIONS REGARDING THIS PLAN

The benefit administration of this Plan is handled by the staff of MEBS. Only employees of MEBS are qualified to answer questions regarding benefits, eligibility, and other terms and conditions of the Plan. Any questions about benefits may be directed to them at the following location:

Michigan Employee Benefit Services, Inc. (MEBS)
3809 Lake Eastbrook Boulevard
Grand Rapids, Michigan 49546
Telephone number: (800) 968-6327

Should an employee desire to inspect or receive copies of additional documents relating to this Plan, contact MEBS, the Benefit Administrator, at the address or phone number shown. The employee/subscriber will be charged a reasonable fee to cover the cost of reproducing any materials he/she wishes to receive.

SUBSCRIBER RESPONSIBILITIES

The following actions by the subscriber will facilitate prompt payment of eligible claims:

(a) When you write to the MEBS Office, please be sure to provide your name and Social Security number in your letter. If you call, please be sure to have your Social Security number handy.

(b) Notify your Employer and the MEBS Office within 30 days after the date you gain or lose a Dependent (spouse or child) for any reason whatever, i.e. divorce separation, birth, death, or age.

(c) If you or one of your Dependents becomes eligible for Social Security benefits and/or Medicare coverage, you must send a copy of the Social Security Award Letter and/or Medicare Card to your employer and the MEBS Office immediately.

(d) Notify the MEBS Office and the Employer's office immediately if you change your home address.

INTERPRETATION OF THE PLAN

The Plan Administrator has sole authority to interpret and apply the provisions of this Plan, and to determine eligibility for coverage and benefits. The decisions of the Plan Administrator and/or Underwriter are final and binding on all parties.
AMENDMENT OF THE PLAN

Subject to labor contract agreements, the employer may amend the Plan at any time.