



**VISION CARE PLAN**  
Summary Plan Description

JANUARY 1, 2008

## **INTRODUCTION**

This booklet is a summary plan description of vision care benefits for Trinity Health as it applies to eligible employees.

Vision care benefits are provided by Spectera. Spectera has an extensive nationwide network of doctors who provide quality eye care and materials. This plan is designed to provide for regular eye examinations and benefits toward vision care expenses including glasses or contact lenses.

Coverage under the Plan is not a guarantee of employment.

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## **Eligibility**

You are eligible to participate in the plan if you are a regularly scheduled full-time or part-time employee, as defined by your Trinity Health Ministry Organization. Coverage will become effective after you satisfy the waiting period as defined by your Trinity Health Ministry Organization (MO).

Shown below is a list of dependents who are eligible for coverage under the plan. Upon enrollment in the plan, you will have 31 days to provide documentation to verify the eligibility of each of your covered dependents. Coverage for your dependents will remain in an “ineligible” status until appropriate documentation is provided. Failure to provide appropriate documentation within 31 days will result in the voluntary termination of coverage for your covered dependents.

**Please note:** If you and your legal spouse (legal spouses are those for whom the IRS recognizes as a legal spouse; common law marriage is excluded) are employed with any Trinity Health MO in a benefits-eligible position, you may either carry individual coverage as employees or one of you may cover the other as a dependent spouse. You and / or your spouse are not eligible to be covered as both an employee and a dependent under any Trinity Health plan. In addition, if both you and your spouse are covered as employees under a Trinity Health plan, only one of you may cover dependent children.

### **Dependent Spouse**

A dependent spouse is eligible for coverage under the plan provided they meet of the following criteria:

- The person is legally married to you. Legal spouses are those for whom the IRS recognizes as a legal spouse; common law marriage is excluded.
- The person is not otherwise covered under any Trinity Health plan.

### **Dependent Children by Birth, Marriage, Adoption, Legal Guardianship or Qualified Medical Child Support Order (QMCSO)**

Dependent children are eligible for coverage under the plan through the end of the calendar year in which they turn age 19, provided they meet all of the following criteria:

- They are unmarried.
- They are the natural, legally adopted or court appointed dependent child of either you and / or your legal spouse (legal spouses are those for whom the IRS recognizes as a legal spouse; common law marriage is excluded).
- They are not otherwise covered under any Trinity Health plan.

Dependent children are eligible for coverage under the plan through the end of the calendar year in which they turn age 24, provided they *also* meet all of the following criteria:

- They meet the IRS definition of a Qualifying Child (does not include qualified child(ren) who are not otherwise covered as described above). A Qualifying Child is one who:
  - ✓ Is enrolled as a full-time student at least five months of the year,
  - ✓ Has the same principal residence as the employee for more than half of the tax year (exceptions apply in certain cases, such as divorce / separation situations, college attendance, etc.), and
  - ✓ Is receiving more than one-half of his / her support from you and / or your legal spouse (legal spouses are those for whom the IRS recognizes as a legal spouse; common law marriage is excluded).

Dependent children who are legally disabled are eligible for coverage beyond age 24, provided they *also* meet all of the following criteria:

- They are enrolled in a creditable plan prior their 19<sup>th</sup> or 24<sup>th</sup> birthday, and
- They are deemed legally disabled by mental or physical incapacity prior to their 19<sup>th</sup> or 24<sup>th</sup> birthday.

### **Who Is Not Eligible For Coverage**

- Your common law spouse;
- Your legal spouse and / or dependent child(ren) if covered under any Trinity Health plan as an employee or dependent;
- Any individual who begins active service in the armed forces of any country, unless coverage is continued as provided under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), and
- Any individual who does not meet the definition of an employee or dependent as described in the section of the Summary Plan Description titled “Who Is Eligible For Coverage.”

### **Enrollment Procedure**

You will be provided with an enrollment form to complete or you may be eligible to enroll for the vision care plan on-line. Whichever method is available to you, the form or online enrollment will allow your employer to deduct the appropriate contributions from your pay. Be sure to sign and return your enrollment form within 31 days of benefits eligibility.

Your contributions toward the cost of coverage will be deducted from your pay and are subject to change. This benefit is a 100 percent employee paid. The rate of any required contributions will be determined by your employer. See your employer for details.

## Effective Date of Coverage

Your coverage will be effective on your benefits eligibility effective date or the date you experience a qualified family status change (see below).

If you fail sign and return your enrollment form within 31 days of your benefits eligibility date, or within 31 days of a qualified family status change, you will have to wait until the next open enrollment period to enroll for vision care benefits. The annual enrollment period takes place prior to the beginning of each plan year.

## Qualified Family Status Change

You may be eligible to change your level of coverage before the next annual enrollment period if you experience a change in status. The change in coverage must be on account of and consistent with a change in status event that affects coverage eligibility of the *employee*, *spouse*, or *dependent*. A qualified family status change includes:

- marriage.
- divorce, legal separation, or annulment.
- birth, adoption, or placement for adoption of a child.
- death of a *spouse* or *dependent child*.
- termination or commencement of employment by you, your *spouse*, or your *dependent child*.
- reduction or increase in hours of employment by you, your *spouse*, or your *dependent child*.
- you, your *spouse*, or your *dependent child* moves out of a coverage area which results in a change in eligibility.
- your *dependent child* satisfies or ceases to satisfy the requirements for coverage due to attainment of age, or any similar circumstance as provided in the *Plan*.
- commencement or return from an unpaid leave of absence by you, your *spouse*, or your *dependent child*.
- a change in worksite of you, your *spouse*, or your *dependent child*.

If you experience such a change in status and wish to change your level of coverage, you must submit written notification to the Human Resources Department within 31 days of your change in status. The Plan Sponsor and/or its designee reserves the right to require the applicant to submit proof of any change in status

## How The Plan Works

When you are ready to obtain vision care services, call your Spectera participating doctor. If you need to locate a Spectera participating doctor, call Spectera (800) 742-9068 or visit the Web site at [www.spectera.com](http://www.spectera.com).

When making an appointment, identify yourself as a Spectera member. The participating doctor will also need the covered member's Social Security number, patient's name and date of birth and the covered member's group name. The participating doctor will contact Spectera to verify eligibility and plan coverage. The participating doctor will also obtain authorization for services and materials. If you are not eligible, the Spectera doctor will notify you.

At your appointment, the participating doctor will provide an eye examination and determine if eyewear is necessary. If so, the participating doctor will coordinate the prescription with a Spectera-approved, contract laboratory. The participating doctor will itemize any non-covered charges and have you sign a form to document that you received services. Spectera will pay the participating doctor directly for covered services and materials.

You are responsible for paying the doctor any applicable copayment(s), and any additional costs resulting from cosmetic options, or non-covered services and materials you selected. Selecting a participating doctor from Spectera's network assures direct payment to the doctor and guarantees quality services and materials.

## Services From a Non-Participating Doctor

More than 90% of Spectera's patients receive services from participating doctors, although you may select any licensed vision care provider for services. ***Your reimbursement schedules does not guarantee full payment, nor can Spectera guarantee patient satisfaction, when services are obtained from a non-participating provider.***

Follow these steps if you obtain services and/or materials from a non-participating provider:

- Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the eye examination, lens type, and frame.
- Send a copy of the itemized bill(s) to Spectera.

The following information **must** also be included in your documentation.

- Member's name and mailing address;
- Member's Social Security number;

➤ Patient's name and date of birth.

You will be reimbursed up to the following amounts:

Examination:	\$ 40.00
Single Vision Lenses:	\$ 40.00
Bifocal Lenses:	\$ 60.00
Trifocal Lenses:	\$ 80.00
Lenticular Lenses:	\$ 80.00
Frames:	\$ 45.00
Elective Contacts:	\$150.00
Medically Necessary Contacts:	\$210.00

### **Covered Benefits**

Eye examination: Once each 12 months\*

Spectacle Lenses: Once each 12 months\*

Frame: Once each 12 months\*

Copayments: \$10.00 Examination  
\$20.00 Materials

*\*from your last date of service*

Spectera covers a wide selection of frames, but not all frames will be covered in full. When a patient selects a frame that exceeds the plan's allowance, these additional charges are administered at controlled costs. For a non-covered frame, the participant will be charged the \$20 copayment plus the difference at Spectera's preferred price. The preferred price is a \$50 wholesale allowance at independent locations or a minimum of \$130 retail frame allowance at retail locations. Spectera also has controlled costs for cosmetic options, and these charges are typically less than usual and customary fees. Please consult your participating provider about lens options which may be cosmetic in nature, and may result in additional charges. Options including progressive lenses, scratch coating (for anything more than the front of the lens), and tints are available at Spectera's preferred price, which is typically 20-40 percent less than retail.

Elective or Medically Necessary contact lenses may be provided instead of glasses.

### **Elective Contact Lenses:**

Spectera covers a wide variety of contact lenses in full, when obtained from a participating provider location. If you select contact lenses outside of Spectera's covered selection, you will receive an allowance of \$150 toward the usual retail cost of the dispensing, fitting and materials. Any amount over the allowance is the patient's responsibility.

Contact lens frequency is the same as spectacle lenses. Under this plan, if you select contact lenses, you will be eligible for a frame **12 months after** the last date of obtaining the contact lenses.

### **Medically Necessary Contact Lenses:**

Contact lenses are covered in full when prescribed by a participating doctor for one of the following conditions:

- Following cataract surgery;
- To correct extreme vision problems that cannot be corrected with spectacle lenses;
- With certain conditions of anisometropia; or
- With certain conditions of keratoconus.

***The participating doctor must secure prior approval from Spectera for Medically Necessary contact lenses.***

### **Limitations**

This plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, you will be responsible for an additional charge:

- Blended lenses;
- Oversize lenses;
- Progressive multifocal lenses;
- Photochromic or tinted lenses
- Coated or laminated lenses;
- A frame that exceeds the plan allowance;
- Certain limitations on low vision care;

- Cosmetic lenses;
- Optional cosmetic processes; or
- UV protected lenses.

### **Exclusions**

The following professional services or materials are not covered. Discounts may apply to some items.

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses (non-prescription)
- Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment; or
- Corrective vision services, treatments, and materials of an experimental nature.

### **Filing Claims**

Please mail the itemized bill(s) and claim form to the following address:

**Spectera**  
**Attn: Claims Department**  
**2811 Lord Baltimore Drive**  
**Baltimore, Maryland 21244-2644**

Claims for reimbursement must be filed within one year of the date services were completed. If a claim is received after one year of the date of service, your claim will be denied.

**Please note:** Receipts must be submitted together for services and materials purchased on different dates to receive reimbursement.

## **Claim Review Procedure**

If a claim for benefits is denied, a written request may be submitted to Spectera for a full review of the denial. This request must be made within 180 days of the denial. To exercise this option, call Spectera at 1-800-742-9068 to obtain details on procedures to follow.

## **Questions**

If you have questions about your Spectera vision plan, please call the toll-free customer service number 1-800-742-9068, Monday through Friday, 8:30AM – 8:00PM Eastern Standard Time (ET).

## **COBRA - CONTINUATION OF BENEFITS**

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended requires that employers of 20 or more employees, continue to provide employees and certain family members, the opportunity to continue coverage under the medical and/or dental plans, in certain instances where coverage under the group health plan would otherwise be terminated.

Continuation coverage for your *health care spending account* is available through the end of the current plan year only if the unused amount available in your account exceeds the amount of the contribution amount required under COBRA and if your coverage or a covered dependent's coverage would otherwise end because:

- your employment ends for any reason other than your gross misconduct.
- your hours of work are reduced so that you are no longer an eligible employee.
- you are divorced or legally separated.
- you die.
- your child is no longer eligible to be a covered dependent (for example, because he or she reaches the limited age).

**HOW TO CONTINUE COVERAGE** - If your coverage would end because of divorce or legal separation, or because your child is no longer eligible to be a dependent, you or your covered dependent must notify the Human Resources Department. If the Human Resources Department is not notified within 60 days after coverage would otherwise end, coverage cannot be continued.

When the Human Resources Department receives this notice (or when your employment ends, your hours of work are reduced so you are no longer an eligible employee, or your death), you and your covered dependents will be notified about your/their right to continue coverage. If you or a covered dependent want to continue coverage, you, he or she must elect to do so within 60 days of the date the notice was received. (You and each of your covered dependents can individually decide whether or not to continue coverage, but the election of coverage by you or your spouse will be

considered to be an election by all covered individuals, unless another covered individual rejects coverage.)

Continuation coverage is identical to the coverage provided to similarly situated active employees and their family members. If coverage for similarly situated active employees and their family members is modified, your continuation coverage will also be modified in the same manner. You will be notified of any such change in advance.

**PREMIUMS** - Continuation of coverage is at your expense, the monthly costs of this continued coverage will be included in the notice sent to you.

For coverage to continue, the first premium must be received in full, by the Cobra Administrator, within 45 days after continuation of coverage is elected. Premiums for every subsequent month of coverage must be paid in full each month, on or before the premium due date stated in the notice sent to you.

There is a 30-day grace period for the monthly premium. If it is not paid within 30 days after the due date, continuation of coverage will end as of the first day of that period of coverage and cannot be reinstated.

**LENGTH OF COVERAGE** - If coverage would otherwise end because your employment ends or your hours are reduced so you are no longer an eligible employee, continuation of coverage for you and/or your covered dependents may continue until the earliest of the following:

- the end of the current Plan year
- the date on which a premium payment was due but not paid.
- the date a covered person becomes covered by another group health plan which does not contain a pre-existing condition limitation affecting eligibility for coverage.
- the date a covered person becomes entitled to Medicare.
- the date Trinity Health terminates its group health plan.

If coverage would otherwise end for a covered dependent (spouse or child) because of divorce, legal separation, death or a child's loss of dependency status, continuation of coverage may continue until the earliest of the following:

- the end of the current Plan Year
- the date on which a premium payment was due but not paid.
- the date a covered person becomes covered by another group health plan which does not contain a pre-existing condition limitation affecting eligibility for coverage.
- the date Trinity Health terminates its group health plan.

## **YOUR RIGHTS UNDER ERISA**

1. As a participant in this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

- A. Examine, without charge, at the Plan Administrator's office, and at other specified locations, all plan documents, including insurance contracts, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
  - B. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for such copies.
  - C. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary report.
2. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the disability Plan.
  3. The people who operate the Plan, who are called "fiduciaries", have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.
  4. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
  5. If your claim for benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim.
  6. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and you do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$100 per day until you receive the materials, unless the materials were not sent due to circumstances beyond the Administrator's control.

7. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay these costs and fees. If you lose the suit, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).
8. If you have any additional questions about the Plan, you should contact the Plan Administrator.
9. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed on page 12, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

The claims administrator must reply to a claim request within a certain time period. The claimant must also respond to the request for additional information from the claims administrator within certain time periods.

### **What if your claim is denied?**

If a claim is partially paid, you will receive a written notice explaining how the claim was processed and giving notice of your appeal rights as to the unpaid portion. If a claim is denied in whole, a written Notice of Benefit Determination will be sent to you. This notice will include:

- The address and timeframe for submitting an appeal.
- A statement that an appeal must be submitted in writing, and any other information that should be included with the appeal request.
- A statement that you have a right to submit written comments, documents, records, and other information relating to the claim.
- A statement that you will be provided, at no charge and upon request, reasonable access to and copies of all documents, records, and other information relevant to the claim.
- A statement that you and the plan may have other voluntary dispute resolution options, such as mediation, and information about how to obtain information about such options.
- A statement that you have a right to bring a civil action under section 502 (a) of ERISA following a denial of an appeal.
- A statement that you will be provided, at no charge and upon request, a copy of any specific internal rules, guidelines, or protocols that were relied upon in denying the claim.
- A statement that you will be provided, upon request and at no additional charge, an explanation of any scientific or clinical basis for denying the claim.

### **What do you do to appeal?**

You, the claimant, or your authorized representative may appeal a denied claim. Appeals must be in writing and received by Spectera within 180 days after your receipt of the Notice of Benefit Determination. If this Notice is not received by you within 30 days of submission of the original claim, you may submit an appeals within 180 days after this 30 day period had expired. Appeals should be submitted to:

Spectera/UHS Vision Appeals  
Claims Department  
P.O. Box 26618  
Baltimore, MD 21207-6618

You or your authorized representative have the right to:

1. Submit a written request for review to the Plan Administrator;
2. Review pertinent documents; and
3. Submit issues and comments, in writing, to the Plan Administrator.

The Plan Administrator will make a full and fair review of the claim and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made no later than 60 days following the Plan Administrator's receipt of your written request for review. If a claim is filed and additional information is needed, the Claims Administrator must notify the claimant within 30 days. The claimant will have up to 45 days from the request to supply the needed information. When the information is received, the Claims Administrator will notify the claimant of a decision within 30 days. If the claimant does not respond to the request for information, the claims will be denied 60 days after the request for information. The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Plan provisions upon which the final decision is based.

## Plan Administration Information

**Name of Plan:**

Trinity Health Corporation Welfare Benefit Plan

**Name and Address of Employer:**

Trinity Health  
34605 Twelve Mile Road  
Farmington Hills, MI 48331

**Employer Identification Number:**

35-1443425

**Who Pays for the Plan:**

The cost of this Plan is paid through Employee contributions.

**Type of Plan:** Welfare

**Plan Number:**

505

**Plan Year:** Jan 1 – Dec 31.

**Plan Administrator:**

Trinity Health  
34605 Twelve Mile Road  
Farmington Hills, MI 48331  
(248) 489-6736

**Benefit/Claims Administrator:**

Spectera  
2811 Lord Baltimore Drive  
Baltimore, Maryland 21244-2644

**Agent for Service of Legal Process:**

Plan Administrator as stated above.

**Department of Labor:**

SPD  
Office of Reporting and Disclosure  
Pension & Welfare Benefit Programs  
U.S. Department of Labor  
Washington, D.C. 20216