Physicians Eyecare Plan

Administrative Office:
48 Courtenay Drive
Charleston, South Carolina 29403
Phone: 1-843-579-0508

GROUP VISION CARE PLAN

Group Name:	Outpatient Medical Associates
Group Number:	00522
Group Effective Date:	January 1, 2020
Group Anniversary Date:	January 1

This Group Vision Care Plan Description ("Plan Description") sets forth your rights and obligations as a Covered Person. It is important that you READ YOUR PLAN DESCRIPTION CAREFULLY and familiarize yourself with its terms and conditions.

This Vision Plan may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost a Subscriber must pay can be obtained from the Enrolling Group.

Physicians Eyecare Plan (the "Company") agrees with the Enrolling Group to provide coverage for Services to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Vision Plan. The Vision Plan is offered on the basis of the Enrolling Group's application and payment of the required Vision Plan charges. The Enrolling Group's application is made a part of the Vision Plan.

Many words used in this Plan Description have special meanings. These words are defined for you in Section 1: Definitions. By reviewing these definitions, you will have a clearer understanding of this Plan Description.

When we use the words "we", "us", "our", and "the Company" in this Plan Description, we are referring to Physicians Eyecare Plan. When we use the words "you" and "your", we are referring to the people who are Covered Persons as the term is defined in Section 1: Definitions.

Telephone inquiries or requests for information about coverage and assistance in resolving complaints should be directed to the following number: 800-368-9609.

GROUP VISION CARE PLAN

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Section 1: Definitions

Copayment - The charge, in addition to the Premium, that you are required to pay to a Network Provider for certain Services payable under the Vision Plan. You are responsible for the payment of any Copayment directly to the provider of the Service at the time of service, or when billed by the provider.

Covered Person - The Subscriber or an Enrolled Dependent; this term applies only while the person is enrolled under the Vision Plan. Reference to "you" and "your" throughout this Plan Description are references to Covered Persons.

Dependent - (1.) The Subscriber's legal spouse; or (2.) a dependent child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, a legally adopted child, a child placed for adoption, or a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse). The term child also includes a dependent grandchild of either the Subscriber or the Subscriber's spouse. To be eligible for coverage under the Vision Plan, a Dependent must reside within the United States. The definition of Dependent is subject to the following conditions and limitations:

A. The term Dependent will not include any dependent child 26 years of age or older, except as stated in Section 3: Termination Provisions, sub-section titled "Extended Coverage for Handicapped Dependent Children".

Eligible Person - A person who meets all applicable eligibility requirements for vision care coverage.

Enrolled Dependent - A Dependent who is properly enrolled for coverage under the Vision Plan.

Enrolling Group - The employer or other defined or otherwise legally established group, to whom the Vision Plan is offered.

Foreign Services - Services provided outside the U.S. and U.S. Territories.

Network Benefits - Coverage for Services provided by a Network Provider.

Non-Network Benefits - Coverage for Services provided by a provider other than a Network Provider.

Network Provider - Any optometrist, ophthalmologist, optician or other person who may lawfully provide Services who has contracted, directly or indirectly, with us, to provide Services to Covered Persons participating in our vision plans.

Plan Summary - A separate document that summarizes the benefits of the Vision Plan.

Plan Year - A period of time beginning with the Group Anniversary Date of any year and terminating exactly one year later. If the Group Anniversary Date is February 29, such date will be considered to be February 28 in any year having no such date.

Premium - The periodic fee required to maintain coverage of Covered Persons in accordance with the terms of the Vision Plan.

Service - Any covered benefit listed in Section 4: Benefits.

Subscriber - An Eligible Person who is properly enrolled for coverage under the Vision Plan.

Vision Plan - The Group Vision Care Plan offered to the Enrolling Group.

Section 2: Eligibility and Effective Dates

Effective Date of Coverage

For Covered Persons beginning on the Group Effective Date of the policy, coverage is effective immediately. For persons who become Covered Persons after the Group Effective Date of the policy, no waiting period is required by the Company. Coverage will be effective subject to any applicable waiting period required by the Enrolling Group. In no event is there coverage for Services rendered or delivered before the Covered Person's effective date.

Enrollment

Eligible Persons may enroll themselves and their Dependents for coverage under the Vision Plan during any enrollment period by submitting a form provided or approved by the Company. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on Group Anniversary Date.
In addition, new Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for coverage under the Vision Plan.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

The Vision Plan does not restrict enrollment based on hours worked, full time, part time working status or retiree unless otherwise stipulated by the Enrolling Group.

Coverage for a Newly Eligible Person

Coverage for you and any of your Dependents will take effect as agreed to by the Enrolling Group and the Company. Coverage is effective only if the Company receives any required Premium and a properly completed enrollment form within 31 days of the date you first become eligible.

Coverage for a Newly Eligible Dependent

You may make coverage changes during the year for any Dependent whose status as a Dependent is affected by a marriage, divorce, legal separation, annulment, birth, legal guardianship, placement for adoption or adoption or a foster child, as required by federal law. In such cases you must submit the required contribution of coverage and a properly completed enrollment form within 31 days of the marriage, birth, placement for adoption or adoption. Otherwise, you will need to wait until the next enrollment period.

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, or a foster child, court or administrative order, or marriage shall take effect on the date indicated by the Enrolling Group. Coverage is effective only if the Company receives any required Premium and is notified of the event within 31 days.

Retroactive Eligibility Changes:

Retroactive eligibility changes are limited to sixty (60) days prior to the date notice of any such requested change is received by PEP. PEP may refuse retroactive termination of a Covered Person if Plan Benefits have been obtained by, or authorized for, the Covered Person after the effective date of the requested termination. Group agrees to provide timely eligibility changes to PEP.

3: Termination Provisions

Termination of Coverage

A Covered Person's coverage will automatically terminate on the earliest of the dates specified below:

1. The date the entire Vision Plan is terminated for the reasons specified in the Vision Plan. The Enrolling Group is responsible for notifying the Subscriber of the termination of the Vision Plan.

2. Covered Person ceases to be an Eligible Person as indicated by the Enrolling Group.

3. When the Company receives written notice from the Enrolling Group instructing the Company to terminate coverage of the Subscriber or any Covered Person.

4. When the Subscriber is retired or pensioned under the Enrolling Group's plan, unless a specific coverage classification is specified for retired or pensioned persons in the Enrolling Group's application and the Subscriber continues to meet any applicable eligibility requirements.

When any of the following apply, the Company will provide written notice of termination to the Subscriber:

1. The date specified by the Company that all coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided the Company with false material information. Such information may include, but is not limited to, information relating to residence, information relating to another person's eligibility for coverage or status as a Dependent. The Company has the right to rescind coverage back to the Group Effective Date.

2. The date specified by the Company that coverage will terminate due to material violation of the terms of the Vision Plan.

3. The date specified by the Company that all coverage will terminate because the Covered Person permitted the use of his or her ID card by any unauthorized person or used another person's card.

Reimbursement for Services

The Covered Person will be responsible for any claims paid by the Company when coverage was provided in error, except where that error was made by the Company.

Extended Coverage for Handicapped Dependent Children

Coverage of an Enrolled Dependent who is incapable of self-support because of mental or physical handicap will be continued beyond the limiting age provided that:

1. The Enrolled Dependent becomes incapacitated prior to attainment of the limiting age;

2. The Enrolled Dependent is chiefly dependent upon the Subscriber for support and maintenance;

3. Proof of such incapacity and dependence is furnished to the Company within 31 days of the date the Subscriber receives a request for such proof from the Company; and

4. Payment of any required contribution for the Enrolled Dependent is continued.

Coverage will continue so long as the Enrolled Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Vision Plan.

Section 4: Benefits

You will be provided with benefits for each of the listed Services as stated in the Plan Summary. Your rights to benefits are subject to the terms, conditions, and exclusions of the Vision Plan, including this Plan Description, and any attached Amendments.

Obtaining Services

To find a Network Provider, you may access a listing of Network Providers online at www.physicianseyecareplan.com. You may also call the provider locator service at 1-800-368-9609.

You also may obtain Services from a non-Network Provider. However, the amount of coverage may be reduced.

Section 5: Benefit Descriptions

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Covered Person resides, to include:

1. Case History – Eye and vision history
2. Visual acuity – near and far
3. External examination, including biomicroscopy or other magnified evaluation of the anterior chamber
4. Refraction – subjective, objective
5. Slit lamp examination
6. Fundus examination
7. Dilation of the eye and eye drops, when indicated
8. Tonometry, when indicated
9. Binocular vision testing, when indicated

Post examination procedures will be performed only when materials are required.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

Eyeglass Frames

A structure that contains eyeglasses lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

Optional Lens Extras

Special lens stock or modifications to lenses that do not correct visual acuity problems. Optional Lens Extras include options such as, but not limited to, tinted lenses, polycarbonate lenses, transition lenses, high-index lenses, progressive lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photochromatic coating.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Medically Necessary Contact Lenses: For plans that include Medically Necessary Contact Lenses

The benefit provides coverage for medically necessary contact lenses from a Network Provider when one of the following conditions exists:

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

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

Section 6: General Provisions

Amendments and Alterations

Amendments to the Vision Plan are effective upon 45 days written notice to the Enrolling Group. Riders are effective on the date specified by the Company. No change will be made to the Vision Plan unless it is made by an Amendment or a Rider that is signed by an officer of the Company. No agent has authority to change the Vision Plan or to waive any of its provisions.

Time Limit on Certain Defenses

No statement made by the Enrolling Group, except a fraudulent statement, will be used to void this Vision Plan after it has been in force for a period of 2 years.

Relationship Between Parties

The relationships between the Company and providers, and the relationship between the Company and the Enrolling Group, are solely contractual relationships between independent contractors. Providers and the Enrolling Group are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of providers or of the Enrolling Group.

The relationship between a provider and any Covered Person is that of provider and patient. The provider is solely responsible for the services provided by it to any Covered Person. The Enrolling Group is solely responsible for enrollment and coverage classification changes (including termination of a Covered Person's coverage through the Company) and for the timely payment of the Vision Plan Charge.

Assignment of Benefits

No assignment of the benefits or of payment for reimbursement is binding unless agreed to in writing. Such agreement is not valid until approved by us.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive you of coverage under the Vision Plan. A clerical error also does not create a right to benefits.

Notice

When the Company provides written notice regarding administration of the Vision Plan to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons.

Workers' Compensation Not Affected

The coverage provided under the Vision Plan does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

Conformity with Statutes

Any provision of the Vision Plan which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Headings

The headings, titles and any table of contents contained in the Vision Plan and Plan Description are for reference purposes only and shall not in any way affect the meaning or interpretation of the Vision Plan and Plan Description.

Unenforceable Provisions

If any provision of the Plan Description is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Plan Description to the greatest extent legally permissible.

Section 7: Claims

Notice of Claim

Notice of claim as determined by us must be given to us within 365 days of the date such loss begins. The notice must be given with sufficient information to identify the Covered Person. Failure to file such notice within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, the notice must be given as soon as reasonably possible.

Payment of Claims

When obtaining Services from a Network Provider, you will be required to pay a Copayment (if applicable) and any charges not covered by the Vision Plan to your Provider. When obtaining Services from a Network Provider, you will not be required to submit a claim form. Benefits may not be combined with provider discounts or promotions. Members who would like to purchase glasses and/or contact lenses under a Network Provider sponsored discount or promotion will be required to pay for the service in full and then file a claim to Physicians Eyecare Plan. Reimbursement will be based on the out of network benefits as described in your group vision plan description.

When obtaining Services from a non-Network Provider, you will be required to pay all billed charges to your provider. You may then obtain reimbursement for the covered portion of Services. Reimbursement will be based on the out of network benefits as described in your group vision plan description.

Reimbursement

To file a claim for reimbursement for Services rendered by a non-Network Provider, or for Services covered as reimbursements (whether or not rendered by a Network Provider or a non-Network Provider), provide the following information on a claim form found at www.physicianseyecareplan.com:

1. Your itemized receipts;
2. Subscriber name;
3. Subscriber's identification number;
4. Patient name; and
5. Patient date of birth.

Submit the above information to us:

By mail:

Physicians Eyecare Plan
Claims Department
48 Courtenay Dr.
Charleston, SC 29403

By facsimile (fax):

843-577-5895

Reimbursements are payable within 45 days of receipt.

Section 8: Complaint Procedures

Complaint Resolution

If you have a concern or question regarding the provision of Services or benefits under the Vision Plan, you should contact the Company's customer service department. Customer service representatives are available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A customer service representative will return your call. If you would rather send your concern to us in writing, please mail correspondence to:

Physicians Eyecare Plan
Customer Service
48 Courtenay Dr.
Charleston, SC 29403

We will notify you of our decision regarding your complaint within 30 days of receiving it.

If you disagree with our decision after having submitted a written complaint, you can ask us in writing to formally reconsider your complaint. If your complaint relates to a claim for payment, your request should include:

Section 8: Complaint Procedures cont.

1. The patient's name and identification number.
2. The date(s) of service(s).
3. The provider's name.
4. The reason you believe the claim should be paid.
5. Any new information to support your request for claim payment.
6. We will notify you of our decision regarding our reconsideration of your complaint within 60 days of receiving it.

Section 9: Refund of Expenses

Refund of Overpayments

If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if:

1. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
2. All or some of the payment made by the Company exceeded the benefits under the Vision Plan; or
3. All or some of the payment was made in error.

The refund equals the amount the Company paid in excess of the amount it should have paid under the Vision Plan.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Vision Plan. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Enrolling Group. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Section 10: Exclusions

The following Services and materials are excluded from coverage under the Vision Plan:

1. Non-prescription items (e.g. Plano lenses).
2. Non-prescription sunglasses.
3. Frames purchased with any type of non-prescription lens.
4. Services that the Covered Person, without cost, obtains from any governmental organization or program.
5. Services for which the Covered Person has been paid under Worker's Compensation Law, or other similar employer liability law.
6. Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.
7. Medical or surgical treatment for eye disease, which requires the services of a physician.
8. Replacement or repair of lenses and/or frames that have been lost or broken unless member is eligible for benefits.
9. Missed appointment charges.
10. Applicable sales tax charged on Services.
11. Services that are not specifically covered by the Vision Plan.
12. Procedures that are considered to be experimental, investigational or unproven. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.

Section 11: Notice of Privacy Practices

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. Our Notice of Privacy Practices applies to all of the records of your care generated by this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information. For a copy of our Notice of Privacy Practices, please contact Physicians Eyecare Plan, 48 Courtenay Drive, Charleston, SC 29403.

Section 12: COBRA

Continuation of Coverage Provisions (COBRA)

COBRA (Consolidation Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

Definitions for This Section

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);
2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);
3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);
4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);
5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);
6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);
7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

A. Electing COBRA Continuation

I. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:

i. The date on which Insurance would otherwise end; and
ii. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.

II. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:

i. The Member’s Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;
ii. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and
iii. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

B. Notice Requirements

I. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.
II. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:

i. The date of the Qualifying Event; or
ii. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:

a. The date of the disability determination;
b. The date of the Qualifying Event; or
c. The date on the Qualified Beneficiary loses coverage due to the Qualifying Event.

III. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:

i. The date of the Qualifying Event; or
ii. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

IV. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.

V. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

C. COBRA Continuation Period

I. 18-month COBRA Continuation

Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

II. 29-month COBRA Continuation

Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

III. 36-Month COBRA Continuation

If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

IV. COBRA Continuation For Certain Bankruptcy Proceedings

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

D. Premium Requirements

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 100%
29 month continuation - 100% during the first 18 months, 100% during the next 11 months
36 month continuation - 100%

E. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

I. The date the Group Policy terminates;
II. 31 days after the date the last period ends for which a required premium payment was made;
III. The last day of the COBRA continuation period.
IV. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;

V. The first date on which the Qualified Beneficiary is: (a) covered under another group Eye Care policy and (b) not subject to any preexisting condition limitation in that policy.