Group Benefit Plan

Virginia Private Colleges
Benefits Consortium, Inc.

UniView Vision

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Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

CERTIFICATE

UNICARE Life & Health Insurance Company certifies that it has issued Group Policy Number GI 131411 to **VIRGINIA PRIVATE COLLEGES BENEFITS CONSORTIUM, INC.** insuring certain employees of your employer.

In this booklet your employer is called the Plan Sponsor.

This booklet describes the benefits provided as of January 1, 2016. Certain terms of the Group Policy which affect your insurance are contained in the following pages.

The Group Policy was issued in the Commonwealth of Virginia. Its laws and rules will govern in resolving any questions about the Group Policy.

While you remain insured, this booklet is your Certificate of Insurance. It replaces any prior booklet given to you for the types of insurance described here.

233 S. Wacker Drive, Suite 3700
Chicago, IL 60606

UNICARE Life & Health
Insurance Company

Lawrence D. Schaible

President and CEO

CONSUMER INFORMATION NOTICE

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided which have not been satisfactorily addressed by your plan, you may contact either of the following offices for assistance:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

Toll-free Phone: 1-877-310-6560
Richmond Metro Area: 1-804-371-9032

E-Mail: ombudsman@scc.state.va.us

Office of Licensure and Certification
9960 Mayland Drive
Suite 401
Richmond, VA 23233-1485
Toll-free Phone: 1-800-955-1819
Richmond Metro Area: 1-804-367-2106
Fax: 804-527-4503
E-Mail: mchip@vdh.virginia.gov
Website: www.vdh.virginia.gov/olc

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

UniCare Life & Health Insurance Company
Grievances and Appeals
233 S Wacker Drive, Suite 3700
Chicago, IL 60606
Phone: 1-888-884-8428

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Virginia Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

Toll-free Phone: 1-877-310-6560
Richmond Metro Area: 1-804-371-9032

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

SCHEDULE OF BENEFITS

PERSONAL AND DEPENDENT VISION EXPENSE INSURANCE

All benefits payable are subject to the provisions, limitations and exclusions contained in the group policy.

LEVEL OF PLAN BENEFIT	
Examinations	
Ophthalmologist or Optometrist	
Preferred Provider	$15 copayment
Nonpreferred Provider	Up to maximum of $50
Lens, Pair	
Plastic Single Vision Prescription	
Preferred Provider	$15 copayment
Nonpreferred Provider	Up to maximum of $50
Plastic Bifocal Prescription	
Preferred Provider	$15 copayment
Nonpreferred Provider	Up to maximum of $80
Plastic Trifocal Prescription	
Preferred Provider	$15 copayment
Nonpreferred Provider	Up to maximum of $110
Frames	
Preferred Provider	No copayment, up to $130 retail value
Nonpreferred Provider	Up to maximum of $100
Contact Lenses	
Preferred Provider - Conventional Lenses	
Elective (1)	Up to $130 retail value
Non-Elective (2)	Covered in full
Preferred Provider - Disposable Lenses	
Elective (1)	Up to $130 retail value
Non-Elective (2)	Covered in full
Nonpreferred Provider	
Elective (1)	Up to a maximum of $130
Non-Elective (2)	Up to a maximum of $210

(1) Elective Contact Lenses - Prescription contact lenses that are selected by the member for cosmetic reasons.

(2) Non-Elective Contact Lenses - Non-elective lenses are provided for reasons that are not cosmetic in nature and have a maximum benefit per benefit period. Non-elective contact lenses are covered when the following conditions have been identified or diagnosed:

a) Extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses; or
b) Keratoconus - unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; or
c) High Ametropia - unusually high levels of near sightedness, far sightedness, or
d) Anisometropia - when one eye requires a much different prescription than the other eye.

Note: If you elect covered Non-Elective Contact Lenses or Elective Contact Lenses within one Benefit Period, no benefits will be available for covered lenses and frames until your next Benefit Period.

Benefits are available once every calendar year for examinations, eyeglass lenses and contact lenses, and once every two calendar years for frames.

Finding a Vision Provider

The Vision plan has an extensive network of Preferred Providers. You can easily find a provider conveniently located near you by checking the directory at www.UniCare.com.

Using a Preferred Provider

By using a Preferred Provider, you minimize your out-of-pocket expenses and receive the benefits of not having to hassle with paperwork, since the Preferred Provider verifies your eligibility and obtains all the necessary information. You simply pay your copayment and any remaining balance at the time of your appointment.

Preferred Providers offer you discount pricing, which is significantly below retail. You receive substantial savings (15%-40% or more) on additional eyewear pair purchases, contact lenses, lens treatments, specialized lenses and various sundry items. You can learn more about these discounts by visiting www.UniCare.com.

Using a Non-Preferred Provider

If you choose to go to a non-preferred (non-network) provider, you must pay the provider directly at the time of service for exams and materials. Out-of-network claims must be submitted by you. Simply submit a claim for reimbursement. When using a non-preferred provider, your coverage may be limited and your out-of-pocket expenses may be greater.

BASIC TERMS

Here, some basic terms of the benefit plan are discussed. Where these terms are used in this booklet, they have the meaning explained here.

Covered Person: means a Plan Member or a dependent with respect to whom a Plan Member is insured by the group policy.

Doctor: means a physician licensed to practice medicine. Such a doctor must be licensed or certified by the state in which the services are rendered and acting within the scope of that license or certificate.

Experimental or Investigational: means any procedure, treatment, facility, supply, device, or drug that:

1. is not generally accepted by the United States vision community as effective for diagnosis, care or treatment; or
2. is subject to research protocols indicating that the procedure, treatment, facility, supply, device, or drug is "experimental or investigational;" or
3. requires the patient to sign a consent form which indicates that the procedure, treatment, supply, device, or drug is "experimental or investigational" or is part of a research or study program; or
4. requires the provider's institutional review board to acknowledge that the procedure, treatment, facility, supply, device, or drug is "experimental or investigational," and subject to the board's approval.

Important Notice – The Insurer may rely upon the advice of vision review groups and other vision experts to determine which services and/or supplies are experimental or investigational. The decisions whether there is enough scientific data and the decision as to whether a service or supply is "experimental or investigational" will be made by the Insurer.

The Insurer will determine, in its discretion, whether a procedure, treatment, facility, supply, device, or drug is "experimental or investigational."

Injury and Illness: In this plan, the word "injury" means an accidental bodily harm. The word "illness" means a sickness that impairs a Covered Person's normal function of mind or body.

Insurer: Benefits are provided through a group insurance policy. The "Insurer" who issued that policy is UNICARE Life & Health Insurance Company. Their home office is located at 233 S. Wacker Drive, Suite 3700, Chicago, IL 60606. Inquiries to the Insurer should be made to that office. Please include your group policy number as shown in the Certificate in the front of this booklet. The Claims and Plan Member Rights section of this booklet tells where and how benefit claims should be made.

Personal and Dependent Insurance: "Personal insurance" means your insurance under the group policy with respect to yourself. The words "dependent insurance" refer to insurance for your dependents under the group policy. The Plan Membership section of this booklet discusses how you may obtain insurance under the group policy for yourself and your qualified dependents.

Plan Member or Member: means a person who is insured by the group policy with respect to himself or herself.

Plan Sponsor: means the employer who makes this benefit plan available to you.

Reasonable and Customary Level: means a charge which is the usual charge made to persons in the same general locality for similar services or supplies.

Important Notice – The Insurer may rely upon cost data and the advice of vision peer review groups and other vision experts to determine the reasonable and customary level. The determination of the "reasonable and customary" level will be made by the Insurer.

PLAN MEMBERSHIP

ELIGIBILITY FOR INSURANCE

This section tells how you may become insured. The term "personal insurance" means your insurance under the group policy with respect to yourself. Reference to "dependent insurance" means your insurance under the group policy with respect to your dependents.

Personal Insurance

To obtain personal insurance, you need to be a qualified employee. You are a "qualified employee" only if you meet all of these requirements:

1. you are a full–time employee of the Plan Sponsor, working for pay on a scheduled normal work week of at least 30 hours, or a part-time employee of the Plan Sponsor, working for pay on a scheduled normal work week of 29 or fewer hours, or
2. you are a pre-65 retiree according to the Plan Sponsor's records, and
3. you perform that work at the Plan Sponsor's usual place of business, except for duties of a kind that must be done elsewhere, and
4. you are in a covered employment class named in the group policy.

Specific information regarding the group policy and its terms may be obtained from the Plan Sponsor.

If you are a qualified employee on January 1, 2016, you are eligible for personal insurance on that date. Otherwise, you become eligible on the first day of the calendar month coinciding with or next following the date you become a qualified employee with the Plan Sponsor.

Dependent Insurance

If you are a qualified employee, you may obtain dependent insurance for your qualified dependents. Your "qualified dependents" are your spouse and children as defined and limited here.

The term "spouse" means your husband or wife. Your marriage must not have ended in a valid divorce decree or annulment.

Reference to your "child" means your direct offspring. The term also includes your stepchild, legally adopted child, foster child, or a child placed with you for the purpose of adoption. Any such child must be under age 26.

Your spouse or child who is a full–time member of a country's armed forces is not a qualified dependent. Your spouse or child who has personal insurance under the group policy may not be your qualified dependent unless he or she elects dependent insurance in place of the similar personal insurance. If you and your spouse both have personal insurance under the group policy, your qualified dependent children may be insured by either, but not both, of you.

You are eligible for dependent insurance on the earliest date that:

1. you are in an employment class covered for dependent insurance; and
2. you are eligible for similar personal insurance under the group policy; and
3. you have a qualified dependent.

Provision for Court Support Orders

If the Plan Sponsor receives a court order to provide medical insurance for a qualified employee's dependent child or spouse, the Plan Sponsor must notify the employee and determine if the child or spouse is eligible for insurance under this group policy. Eligibility determinations will be made in accordance with federal and/or state support order laws and regulations. The employee will be responsible for any contributions required under the group policy.

The insurance provided in accordance with a support order will be effective as of the date of the support order and subject to all the provisions of the group policy; except:

1. a qualified dependent may be covered without personal insurance in effect under the group policy;
2. in addition to the reasons for termination of insurance shown in the Discontinuance of Insurance provision, the insurance required by a support order will cease on the earlier of the date the support order expires or the date the dependent child or spouse is enrolled for similar insurance.

The group policy will honor all applicable state Medicaid laws and rules, and will not deny insurance or benefits because a person is eligible for Medicaid.

If covered expenses for a dependent child or spouse are paid by the spouse, a custodial parent or a legal guardian who is not a Plan Member, reimbursement will be made directly to the spouse, custodial parent or legal guardian rather than to the Plan Member or eligible employee. A custodial parent or legal guardian may also sign claim forms and assign plan benefits for the dependent child.

A child or spouse will not be considered a late applicant as explained in the Effective Date of Insurance section if a court has ordered that coverage be provided for the child or spouse under your plan, and the request for enrollment is made within 31 days after issuance of the court order.

EFFECTIVE DATE OF INSURANCE

Once you have become eligible for insurance, this section tells when your insurance will begin.

Personal Vision Insurance

Except as explained in the Late Applicant Provisions below, your personal medical insurance will begin on the first day of the policy month coinciding with or next following the date you become eligible for such insurance.

The Plan Sponsor may require employees to contribute toward the cost of all or part of their personal medical insurance. Any such contributory insurance will not become effective for you before you complete an enrollment form and agree to make those contributions. The enrollment form may be obtained from the Plan Sponsor.

Dependent Vision Insurance

Except as explained in the Late Applicant Provisions below, any dependent insurance for which you are eligible will begin on the first day of the policy month coinciding with or next following the date that:

1. you have similar personal insurance in effect under the group policy; and
2. you have a qualified dependent who can be insured as discussed in this section.

The Plan Sponsor may require employees to contribute toward the cost of all or part of their dependent vision insurance. If so, the only qualified dependent who may become insured before you sign an enrollment form and agree to those contributions is your newborn child. The enrollment form may be obtained from the Plan Sponsor.

Your newborn child is insured from the date he or she is born. Within 31 days after the child is born, you need to tell the Plan Sponsor and agree to any required contributions toward the cost of the child's insurance. Otherwise, insurance for the child will cease at the end of that 31 day period.

You may acquire a new qualified dependent while your insurance for other dependents is in effect. If so, the new dependent will automatically become insured.

DISCONTINUANCE OF INSURANCE

Your personal and dependent vision insurance coverage will cease on the first to occur of these dates:

1. the date the group policy is discontinued.
2. the last day of the policy month during which you are no longer eligible for that coverage. This may be due to a change in the group policy or because you transfer to an employment class that is not eligible.
3. the date ending the last period for which you made any required contribution toward the cost of that insurance.
4. the last day of the policy month in which you cease active work for the Plan Sponsor, except that if you are disabled or on a leave of absence or temporary layoff, your insurance may continue up to any time limit imposed by the group policy.

Specific information regarding the group policy and its terms may be obtained from the Plan Sponsor.

Your insurance for any one dependent will not continue beyond the last day of the calendar year in which he or she ceases to be your qualified dependent. The only exception is discussed in the next section.

Handicapped Child Extension

If your insured child is handicapped upon reaching the age limit for qualified dependents, you may continue his or her dependent vision insurance as discussed here. The term “handicapped” means that the child is physically or mentally unable to earn a living. In order to continue the child’s insurance, proof of the handicap must be given to the Insurer at reasonable intervals. The first proof is due within 31 days after the child reaches the age limit for qualified dependents.

See the Plan Sponsor for the needed proof forms. Premiums for the child’s insurance will not change.

The Insurer, at its expense, may have its doctor examine the child at reasonable intervals; but such exams will not be more than once a year after the second year that the child’s insurance has been continued under this section. In no event will the child remain insured beyond the date his or her insurance would cease had the child not reached the age limit for qualified dependents.

COVERAGE PROVISIONS

DESCRIPTION OF THE COVERAGES

The pages of this section specify when plan benefits will be paid. Any conditions governing whether and how much benefit is paid for those events are also discussed in this section.

To receive plan benefits, you must be insured as described in the Plan Membership section of this booklet. Then, your amounts of insurance are determined by the Schedule of Benefits.

Should you become entitled to benefits, the Claims and Plan Member Rights section of this booklet tells how to present your claim.

VISION CARE COVERAGE

Benefits

The insurer will pay a benefit in the amount of the covered expenses that a covered person incurs while insured by this coverage. The "covered expenses" are discussed in the next section.

The maximum benefits for this coverage are shown in the schedule of Benefits of this booklet. Those maximums are the most that the insurer will pay, based on any one person's covered expenses.

Covered Expenses

Covered expenses are the charges made for the necessary services and supplies listed here. Each charge is deemed incurred on the date the service or supply is furnished. Except as limited in the next section, covered expenses include:

1. Charges for examinations by a licensed ophthalmologist or optometrist.
2. Charges for lenses, provided they are prescribed as a result of an examination for which a benefit is payable under this coverage.
3. Charges for frames purchased in conjunction with such newly prescribed lenses.
4. Charges for contact lenses

Excluded Expenses

This coverage is subject to the General Exclusions shown in this booklet. Vision care "covered expenses" also exclude:

1. Charges for routine examinations required by an employer in connection with a covered person's employment.
2. Charges for more than one examination or more than one pair of lenses in any benefit period, unless the examination shows the existing lenses: (a) result in a visual defect equal to at least one diopter in strength; or (b) require a change of at least 20% in axis for astigmatism.
3. Charges for more than one purchase of frames in any benefit period.
4. Charges for: (a) the repair of frames; or (b) duplicate or spare lenses or frames; or (c) sunglasses.

PROVISION FOR PREFERRED PROVIDERS

Definitions

The following definitions are used in this provision. All other definitions of the group policy will also apply.

Preferred Provider: means any health care provider designated as such by the Insurer. A list of preferred providers will be provided to any Plan Member who is eligible for this coverage.

Nonpreferred Provider: means any health care provider who is not designated as a preferred provider by the Insurer.

Service Charge: means an amount paid by a Covered Person directly to a preferred provider before benefits become payable under the group policy when certain vision services or supplies are furnished. Any amount used to satisfy a service charge can not be used to satisfy any deductible amount that may apply to the group policy. Only covered expenses can be used to satisfy a service charge.

Effect on Vision Benefits

All the provisions of the group policy will apply to this provision except:

1. Benefits payable under this provision for covered expenses incurred by a Covered Person from a preferred provider will be payable at the preferred provider level of benefit shown on the Schedule of Benefits.
2. Certain benefits payable for covered expenses incurred from preferred providers will always be paid at the benefit level shown on the Schedule of Benefits. These covered expenses, however, may subject to a service charge before benefits become payable. The Schedule of Benefits indicates those benefits subject to a service charge.

Out of Service Area Non–Emergency Vision Benefits

Preferred provider benefits may be payable for covered expenses incurred by: (a) a Covered Person traveling outside of his or her normal service area, or (b) a covered dependent residing outside the service area who meets the group policy's definition of a full–time student. Covered expenses will include non–emergency vision services provided outside of a hospital emergency room. For information concerning the availability of a preferred provider in your

travel location, please call the telephone number shown on your identification card.

Free Choice of Providers

A Covered Person has a free choice of any provider for his or her vision care. At any time, the Covered Person may choose any preferred or nonpreferred provider. The terms of this Provision for Preferred Providers, however, will only apply to those services and supplies that are furnished by a preferred provider.

Assignment of Vision Benefits

As discussed in the group policy's Coverage Provisions, a Covered Person may assign vision benefit payments directly to the health care provider on whose charges the benefit claim is based. If, however, a Covered Person utilizes the services of a preferred provider, all vision benefit payments will automatically be assigned directly to the preferred provider.

GENERAL EXCLUSIONS

The group policy's Vision Expense Insurance does not provide benefits for:

1. Any part of the charges for services or supplies that exceeds a reasonable and customary level. The Insurer will determine that level. It may base that level on the charges made to other persons in the same locality for similar services or supplies.
2. Any charges procedures, treatment, supplies, or devices that the Insurer determines are experimental or investigational.
3. Charges made by the Covered Person's immediate family; this means the person's spouse, brother, sister, parent or child. Also excluded are charges that the Covered Person has no legal obligation to pay; but this does not exclude the cost of services or supplies provided by a state's Medicaid program.
4. Any part of the normal charge for services or supplies which the provider offers to waive, such as the part that would not be paid by the group policy due to its deductible or copayment provisions.
5. An injury or illness arising out of or in the Covered Person's commission of a felony. Also excluded is an injury or illness resulting from war, whether or not it is a declared war.
6. An injury or illness for which the Covered Person is eligible for benefits under any Workers' Compensation law.
7. Any charges for services or supplies that are solely provided for educational, developmental or vocational purposes, as determined by the Insurer.

REDUCTION IN BENEFITS DUE TO MEDICARE

Definitions

Full Medicare Coverage: means the health insurance provided by Title XVIII of the Social Security Act, as amended. This includes coverage under both Part A Hospital Insurance and Part B Medical Insurance. If a Covered Person is eligible for either part, he or she will be deemed to have Full Medicare Coverage, even if he or she does not enroll for it.

Primary Basis: means that the benefits payable under the group policy will be determined and paid without regard to Full Medicare Coverage.

Secondary Basis: means that the Insurer will reduce its benefit payment so that the total amount payable by Full Medicare Coverage and the group policy will not exceed the actual covered expenses payable by the group policy.

Covered Person: means, for the purpose of this provision, a Covered Person or covered dependent who is covered by the group policy and is entitled to benefits under Full Medicare Coverage.

How Medicare Reduction Works

If a Covered Person incurs covered expenses for which benefits are payable under the group policy, then the Insurer will determine whether his or her coverage under the group policy is payable on a Primary or Secondary Basis to Full Medicare Coverage.

Deciding whether a Covered Person's coverage is payable on a Primary or Secondary Basis will be based on the Covered Person's status on the date the covered expense is incurred.

Active Employees

The group policy will always pay on a Primary Basis when a Covered Person is an active employee or the dependent of an active employee. If, however, a Covered Person is entitled to benefits under Full Medicare Coverage because of end–stage renal disease, the group policy will pay on a Primary Basis only during the first 30 months he or she is so entitled, regardless of whether the Covered Person becomes eligible for Medicare based on age or disability during that 30 month period.

COORDINATION OF BENEFITS PROVISION

This provision applies to persons covered by the group policy and one or more other vision plans. In this case, the plans together may limit their total benefits as explained in Section III - "Effect Of This Provision On The Benefits Of This Plan".

Section I - Definitions

When used in this provision, these words and phrases have the meanings explained here:

Plan: means any of these that provide benefits or services for, or because of, vision care or treatment:

1. Group insurance or group–type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It does not include school–accident type coverage.
2. Coverage under a governmental plan, or coverage required or provided by law. This would include any legally required, no–fault motor vehicle liability insurance. This does not include a state plan under Medicaid or any plan when, by law, its benefits are in excess of those of any private insurance program or other non–governmental program.

Each contract or other arrangement for coverage as defined above will be considered a separate plan. If an arrangement has two parts and the rules of this provision apply only to one of the two parts, each of the two parts is a separate plan.

This Plan: means the part of the group policy that provides the benefits for vision or dental care expenses.

Primary Plan: means that this plan will determine its benefits before those of the other plan and without considering the other plan's benefits.

Secondary Plan: means that this plan will determine its benefits after those of the other plan. The benefits of this plan may be reduced because of the other plan's benefits.

When there are more than two plans covering a person, this plan may be a primary plan as to one or more other plans, and it may be a secondary plan as to a different plan or plans.

Allowable Expense: means a necessary, reasonable, and customary item of expense for vision care when the item is covered, at least in part, by one or more plans covering the person for whom claim has been made.

When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered both an allowable expense and a benefit paid.

Claim Period: means a calendar year. However, it does not include any part of a year: (a) during which a person has no coverage under this plan; or (b) before the date this provision or a similar provision becomes effective.

Section II - Benefit Determination

The sequence in which plans will cover allowable expenses is determined by the plans. Plans with no coordination provision are always first. As to plans that have coordination provisions, this plan will determine the order of benefits using the first of the following rules that apply:

1. The benefits of the plan that cover the person as other than a dependent are determined before those of the plan that cover the person as a dependent.
2. Except as provided in (3) below, coverage of the Plan Member's dependent child is determined as explained here:
   a. the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
   b. if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

   If the rules set forth in (2) above are not a part of each parent's plan, the plan of the parent that does not include these rules will decide the order of coverage.
3. Coverage of the Plan Member's dependent who is the child of divorced or separated parents shall be determined as follows:
   a. coverage through either parent decreed by a court as financially responsible for the allowable expenses is ahead of other dependent coverage;

b. then, or if there is no court decree, coverage through the parent with custody of the child is ahead of other dependent coverage;
c. then, if the parent with custody of the child is remarried, coverage through the step–parent is ahead of other dependent coverage;
d. then, or if there is no remarriage, coverage through the parent without custody of the child is ahead of other dependent coverage.

4. The benefits of a plan which covers a person as an employee who is neither laid off nor retired or as such employee's dependent are determined before those of a plan which covers that person as a laid off or retired employee or as such employee's dependent. However, if the other plan does not include this rule, and each plan determines its benefits after the other, this rule will not be applied.
5. The benefits of the plan that cover the person for a longer period of time are determined before those of the plan that covered that person for a shorter period of time.

Section III - Effect Of This Provision On The Benefits Of This Plan

This section will apply when this plan is a secondary plan to one or more other plans.

Reduction In This Plan's Benefits

The benefits of this plan will be reduced when the sum of:

1. the benefits that would be payable for the allowable expenses under this plan in the absence of this provision; and
2. the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like this provision, whether or not claim is made;

exceeds those allowable expenses in a claim period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of this plan are reduced as described in this section, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

Section IV - Right To Receive And Release Needed Information

Certain facts are needed to apply the rules of this provision. The Insurer has the right to decide which facts it needs. It may get the needed facts from or give them to any other organization or person. The Insurer need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the Insurer any facts it needs to pay the claim.

Section V - Facility Of Payment

A payment made under another plan may include an amount which should have been paid under this plan. If it does, the Insurer may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit payable under this plan. The Insurer will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services; in which case, “payment made” means the reasonable cash value of the benefits provided in the form of services.

Section VI - Right Of Recovery

If the amount of payments made by the Insurer is more than it should have paid under this provision, it may recover the excess from one or more of the following:

1. the persons it has paid or for whom it has paid;
2. insurance companies; or
3. other organizations.

The “amount of payments made” includes the reasonable cash value of any benefits provided in the form of services.

CLAIMS AND PLAN MEMBER RIGHTS

How To Claim Benefits

Due written proof of claim is required in order to receive benefits under the group policy.

Notice of Claim

Notice of a claim must be given within 20 days after a covered loss starts, or as soon as reasonably possible. Written notice can be given to the Insurer at its home office or to the Insurer's agent. Reference to a "loss" merely means that an event occurred or an expense was incurred for which a benefit is payable under the group policy. The notice must identify you along with the group policy number shown in this booklet.

Claim Forms

When the Insurer receives the notice of claim, it will send the claimant forms for filing proof of loss. The needed forms may also be obtained from the Plan Sponsor. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving the Insurer a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

Proof of Loss

Due written proof of loss must be given to the Insurer within 90 days after such loss. Failure to furnish the proof within that time shall not invalidate or reduce the claim if the proof is given as soon as reasonably possible. But, unless delayed by the claimant's legal incapacity, the required proof must be furnished within 2 years of the specified time.

Filing Claim Forms

The proof of loss "claim forms" contain instructions as to how they should be completed and where they should be sent. Be sure to fully complete your portion of the forms. Unanswered questions may delay the processing of your claim.

Your doctor will normally show his or her charges in his or her part of the claim form. If there are other vision charges, you should attach the actual bills. These bills must show:

1. the name of the person or firm making the charge;
2. the name of the patient;
3. the dates of treatment;

4. the service rendered, diagnosis of condition treated, and the amount charged.

If your vision treatment covers a long period of time, please submit bills periodically. Do not submit bills covering several members of your family; separate bills are required for each patient.

Remember, the actual bills will be needed. Cancelled checks, cash register receipts or a list of expenses you prepared yourself cannot be accepted as proof of loss.

Payment of Claims

All benefits will be paid as soon as the insurer receives the required proof of loss.

In the event the insurer does not pay medical expense benefits within 15 working days of its receipt of proof of loss, the insurer will pay interest at the rate required by law on the benefits due under the terms of the policy. No interest will be paid if the total interest due is less than $5.00. This paragraph does not apply to claims for which payment may be made directly to preferred providers under any Provision For Preferred Providers.

All benefits are payable to the plan member. But, if the plan member is unable to execute a valid release, the insurer can:

1. pay any providers on whose charges the claim is based toward satisfaction of those charges; or
2. pay any person or institution that has assumed custody and principal support of the plan member; this will not be done, though, after claim is made by a duly appointed legal representative of the plan member.

If the plan member dies while any accrued benefits remain unpaid, the insurer can pay any provider on whose charges the claim is based toward satisfaction of those charges. Then, any benefits that still remain unpaid can be paid to anyone related to the plan member by blood or marriage.

The insurer will be discharged to the extent of any payments made in good faith under this Payment of Claims provision.

Legal Actions

There are time limits as to when legal action can be taken to obtain group policy benefits. No legal action can be taken until 60 days after written proof of loss has been given as discussed above. No legal action can be taken more than 2 years after written proof of loss was required by the above terms. Legal action with respect to a claim that has been denied, in whole or in part, shall be contingent upon having obtained the Insurer's reconsideration of that claim, as explained next in this section.

Reconsideration Of A Denied Claim

If you are a Plan Member or a member's beneficiary, and your benefit claim is totally or partially denied, the Insurer will give you a written notice. The notice will give the reasons for denial. If you do not agree with the reasons given, you may request reconsideration of your claim.

To do so, you should write to the Insurer within the 60 days after you received the notice of denial. The Insurer's name and address appear in this booklet. They will also be on the notice of denial. You should say why you believe the claim was not properly denied. Include any data, questions or comments that you think are appropriate. Unless the Insurer requests additional material in a timely fashion, you will be advised of its decision within 60 days after your letter is received.

SUMMARY PLAN DESCRIPTION

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your Certificate. But, this document, together with the attached Certificate, issued by UNICARE Life & Health Insurance Company, constitutes the Summary Plan Description required by ERISA.

Plan Name. The designated name of the Plan is:

Virginia Private Colleges Benefits Consortium Welfare Plan

Plan Sponsor. The name and address of the entity which established and maintains the Plan is:

Virginia Private Colleges Benefits Consortium, Inc.
118 East Main Street
Bedford, VA 24523

Plan Numbers:

Employer Identification Number (EIN): **27-1367957**
Plan Number: **501**

Type of Plan. The Plan is an employee welfare benefit plan providing group health benefits.

Source of Plan Contributions. The contributions necessary to finance the Plan are provided by the Plan Sponsor and Employees.

Plan Year. The Plan's records are maintained on a plan year basis beginning each year on January 1st and ending on the following December 31st.

Type of Administration/Funding. Benefits are furnished under a health care plan purchased by the Plan Sponsor and provided by UNICARE Life & Health Insurance Company (UNICARE) under which UNICARE is financially responsible for the payment of claims.

UNICARE's address is:

UNICARE Life & Health Insurance Company
233 S. Wacker Drive, Suite 3700
Chicago, IL 60606

Plan Administrator. The name, address and phone number of the Plan Administrator is:

Tim Klopfenstein
Virginia Private Colleges Benefits Consortium, Inc.
118 East Main Street
Bedford, VA 24523
(540) 586-1803

Agent for Services of Legal Process. The name and address of the designated agent for the service of legal process for the Plan is:

Tim Klopfenstein
Virginia Private Colleges Benefits Consortium, Inc.
118 East Main Street
Bedford, VA 24523

Description of Benefits. The certificate pages set forth the benefits, copays, benefit maximums, limitations and exclusions under the Vision Plan. A brief explanation of these benefits, copays, benefit maximums, limitations and exclusions may be found in the section titled SUMMARY OF BENEFITS. A more detailed description appears in the sections titled VISION CARE COVERAGE; GENERAL EXCLUSIONS and COORDINATION OF BENEFITS PROVISION.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask your employer or Plan Administrator to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Eligibility for Participation. The eligibility requirements for participation under the Vision Plan are set forth in the certificate booklet in the section titled PLAN MEMBERSHIP under the subsections ELIGIBILITY FOR INSURANCE and EFFECTIVE DATE OF INSURANCE.

Grounds for Ineligibility or Loss or Denial of Benefits. Details describing the circumstances which may result in: (a) disqualification from the Vision Plan; (b) ineligibility for benefits; or (c) denial, loss, forfeiture or suspension of benefits under the Plan are set forth and identified in the certificate booklet, as outlined below:

- Reasons for ineligibility or loss of benefits may be found in the section titled PLAN MEMBERSHIP under the subsection DISCONTINUATION OF INSURANCE.
- Benefits may be denied or suspended if statements a Plan participant has made in connection with obtaining coverage were false.
- Information concerning situations under which benefits may be reduced or denied may also be found in the SUMMARY OF BENEFITS and BASIC TERMS sections and in the sections identified in the DESCRIPTION OF BENEFITS portion of this summary.

Claim Procedures. The certificate contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or UNICARE. In addition to this information, ERISA applies some additional claim procedures rules. The addition rules required by ERISA are set forth below.

Urgent Care. UNICARE must notify you, within 72 hours after they receive your request for benefits, that they have it and what they determine your benefits to be. If your request for benefits does not contain all the necessary information, they must notify you within 24 hours after they get it and tell you what information is missing. Any notice to you by them will be orally, by telephone, or in writing by facsimile or other fast means. You have at least 48 hours to give them the additional information they need to process your request for benefits. You may give them the additional information they need orally, by telephone, or in writing by facsimile or other fast means.

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72 hours after UNICARE's receipt of the request for benefits, or 48 hours after receipt of all the information they need to process your request for benefits if the information is received within the time frame noted above. The notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision was based. You have 180 days to appeal their adverse benefit determination. You may appeal their decision orally, by telephone, or in writing by facsimile or other fast means. Within 72 hours after they receive your appeal, they must notify you of their decision, except as otherwise noted below. They will notify you orally, by telephone, or in writing by facsimile or other fast means. If your request for benefits is no longer considered urgent, it will handled in the same manner as a Non-

Urgent Care Pre-Service or Post-Service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). UNICARE must notify you within 15 days after they receive your request for benefits that they have it and what they have determined your benefits to be. If they need more than 15 days to determine your benefits, due to reasons beyond their control, they must notify you within that 15 day period that they need more time to determine your benefits. But, in any case, even with an extension, they cannot take more than 30 days to determine your benefits. If you do not properly submit all the necessary information for your request for benefits to them, they must notify you, within 5 days after they get it and tell you what information is missing. You have 45 days to provide them with the information they need to process your request for benefits. The time period during which UNICARE is waiting for receipt of the necessary information is not counted toward the time frame in which UNICARE must make the benefit determination.

If your request for benefits is denied in whole or in part, you will receive a written notice of the denial within the time frame stated above after UNICARE has all the information they need to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180 days to appeal their adverse benefit determination. Your appeal must be in writing. Within 30 days after they receive your appeal, they must notify you of their decision about it. Their notice of their decision will be in writing.

Concurrent Care Decisions:

- **Reduction of Benefits** – If, after approving your request for benefits in connection with your illness or injury, UNICARE decides to reduce or end the benefits they have approved for your, in whole or in part:
  - They must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal their decision before the reduction in benefits or end of benefits occurs. In their notice to you, UNICARE must explain their reason for reducing or ending your benefits and the plan provisions upon which the decision was made.

- To keep the benefits you already have approved, you must successfully appeal UNICARE's decision to reduce or end those benefits. You must make your appeal to them at least 24 hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24 hours to the occurrence of the reduction or ending of benefits, your appeal may be treated as if you were appealing an urgent care denial of benefits (see the section "Urgent Care" above), depending upon the circumstances of your condition.
- If UNICARE receives your appeal for benefits at least 24 hours prior to the occurrence of the reduction or ending of benefits, they must notify you of their decision regarding your appeal within 24 hours of their receipt of it. If UNICARE denies your appeal of their decision to reduce or end your benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see the section "Urgent Care" above).

- **Extension of Benefits** - If, while you are undergoing a course of treatment in connection with your illness or injury, for which benefits have been approved, you would like to request an extension of benefits for additional treatments:
  - You must make a request to UNICARE for the additional benefits at least 24 hours prior to the end of the initial course of treatment that had been previously approved for benefits. If you request additional benefits when there is less than 24 hours till the end of the initially prescribed course of treatment, your request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an Urgent or Non-Urgent Care Pre-Service request for benefits.
  - If UNICARE receives your request for additional benefits at least 24 hours prior to the end of the initial course of treatment, previously approved for benefits, they must notify you of their decision regarding your request within 24 hours of their receipt of it if your request is for urgent care benefits. If UNICARE denies your request for additional benefits, in whole or in part, they must explain the reason for their denial of benefits and the plan provisions upon which the decision was made. You may appeal the adverse benefit

determination according to the rules for appeal for Urgent, Pre-Service or Post-Service adverse benefit determinations, depending upon the circumstances.

Non-Urgent Care Post-Service (reimbursement for cost of medical care). UNICARE must notify you within 30 days after they receive your claim for benefits, that they have it and what they determine your benefits to be. If they need more than 30 days to determine your benefits, due to reasons beyond their control, they must notify you within that 30 day period that they need more time to determine your benefits. But in any case, even with an extension, they cannot take more than 45 days to determine your benefits. If you do not submit all the necessary information for your claim to them, they must notify you, within 30 days after they get it and tell you what information is missing. You have 45 days to provide them with the information they need to process your claim. The time period during which UNICARE is waiting for receipt of the necessary information is not counted toward the time frame in which UNICARE must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above, or after UNICARE has all the information they need to process your claim, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial decision is based. You have 180 days to appeal their decision. Your appeal must be in writing. Within 60 days after they receive your appeal, they must notify you of their decision about it. Their notice to you of their decision will be in writing.

Note: You or your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with UNICARE and request a review of the denial. In connection with such a request:

- Documents pertinent to the administration of the Plan may be reviewed free of charge; and
- Issues outlining the basis of the appeal may be submitted.

You may have representation throughout the appeal and review procedure.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other locations, such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions. The Plan Administrator may make a reasonable charge for the copies.
- 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 financial report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting

condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of your benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials requested and to pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or federal court, except that, any dispute concerning denial or partial denial of a claim must be resolved by binding arbitration as provided in the Plan booklet unless otherwise prohibited under any applicable state or federal law. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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 court costs and legal fees. If you are unsuccessful, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

In accordance with state insurance law, this booklet is composed of the following forms on file with the State Insurance Department.

CERTIFICATE: GCR 100

SCHEDULE OF BENEFITS: GCR 130, GCR 131, GCR 132

BASIC TERMS: GCR 1127, GCR 1128, GCR 1129, GCR 1130, GCR 1169, GCR 1173, GCR 1196, GCR 11160, GCR 11161

ELIGIBILITY: GCR 120, GCR 121

EFFECTIVE DATE: GCR 12483, GCR 12484, GCR 12485, GCR 12486, GCR 12487

DISCONTINUANCE OF INSURANCE: GCR 124, GCR 125

COVERAGE PROVISIONS: GCR 140

VISION COVERAGE: GCR 320, GCR 321

PREFERRED PROVIDERS: GCR 4435, GCR 4436

GENERAL EXCLUSIONS: GCR 14774, GCR 14775, GCR 14445, GCR 14446

BENEFITS CEASE: GCR 14163, GCR 14304

COORDINATION OF BENEFITS: GCR 14460, GCR 14461, GCR 14267, GCR 14268, GCR 14269, GCR 14270, GCR 14271

CLAIMS: GCR 170, GCR 1720, GCR 1721, GCR 17013

FEDERAL CONTINUATION RIGHTS

THE FOLLOWING IS A SUMMARY OF COBRA (THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985, AS AMENDED) THIS SUMMARY DOES NOT SATISFY THE NOTICE REQUIREMENTS OF FEDERAL LAW.

Continuation Rights as an Employee

If you are an employee covered by this group health plan, you have the right to choose Continuation Coverage if you lose your group health coverage because of a reduction in your hours of employment or termination of your employment, except for reasons of gross misconduct on your part.

Continuation Rights as a Spouse

If you are the spouse of an employee covered by this group health plan, you have the right to choose Continuation Coverage for yourself if you lose group health coverage under this plan due to:

1. the death of the employee;
2. termination of the employee's employment (for reasons other than gross misconduct) or reduction in his or her hours of employment;
3. divorce or legal separation; or
4. the employee's entitlement to Medicare.

Continuation Rights as a Dependent Child

A dependent child of an employee covered by this group health plan has the right to Continuation Coverage if his or her group health coverage is lost due to:

1. the death of the employee;
2. termination of the employee's employment (for reasons other than gross misconduct) or reduction in his or her hours of employment;
3. divorce or legal separation;
4. the employee's entitlement to Medicare; or
5. the dependent ceasing to be a dependent child as defined under this group health plan.

Continuation Rights as a Newly Acquired Dependent Child

If you acquire a dependent child while you are on Continuation Coverage, that dependent child will have the same rights as a dependent who was entitled to Continuation Coverage at the time you initially became eligible for Continuation Coverage.

Continuation Rights Due to Chapter 11 Bankruptcy

If an employer files Chapter 11 Bankruptcy, certain retirees and their dependents may be able to elect Continuation Coverage. If you are a retiree or dependent spouse or child of a retiree and you lose group health coverage due to Chapter 11 Bankruptcy, you should see your former employer for what rights of Continuation Coverage, if any, you might have.

Notice Requirements

The law requires that the employee or family member inform the Plan Administrator, within 60 days, of a divorce, legal separation or when a child is no longer a dependent as defined under this group health plan.

If the Plan Administrator is someone other than your employer, then your employer has the responsibility to notify the Plan Administrator, within 30 days, in the case of an employee's death, termination of employment, reduction in hours, Medicare entitlement or the employer's bankruptcy.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you, within 14 days, that you have a right to choose Continuation Coverage. You then have 60 days from the date you would lose coverage or the date of the notice, whichever is greater, to elect Continuation Coverage.

Each person who loses group health coverage has a separate right to make an election. If Continuation Coverage is not elected, group health coverage may end.

Premium Payment

A person electing Continuation Coverage will be required to pay the applicable premium. In most cases, the maximum amount that may be charged for Continuation Coverage is 102% of the applicable group premium.

The first premium for Continuation Coverage is due by the 45th day following the date the person elects Continuation Coverage.

You have the right to make all future premium payments on a monthly basis. However, annual, semi–annual or quarterly payments may also be made if you and your employer so agree. A grace period of 30 days (or one equal in length to the employer's grace period, if longer) will be allowed for late payment of any monthly premium.

Failure to pay the premium by the end of the grace period may result in termination of Continuation Coverage without further notice.

Length of Continuation Coverage

The maximum length for Continuation Coverage is 18 months when the cause for loss of coverage is termination of your employment or a reduction in your hours. In all other cases, the Continuation Coverage period is 36 months. Continuation Coverage, however, may terminate before the end of the 18 or 36 month period when:

1. your former employer no longer provides group health coverage to any of its employees;
2. the premium for Continuation Coverage is not paid by the end of the grace period;
3. you become covered under another employer–sponsored health plan, except when any pre–existing condition(s) you have are excluded from coverage by the new plan; or
4. you become entitled to Medicare.

When Continuation Coverage terminates, you will be allowed to convert to an individual health conversion policy, if a health conversion privilege is available to similarly situated active employees.

If your Continuation Coverage terminates and you are employed by a new employer at that time, your employer must allow you to enroll in the plan if you request enrollment within 30 days after Continuation Coverage terminates.

Extension of Continuation Coverage

If you and your spouse or dependent children have elected Continuation Coverage for 18 months due to termination of your employment or reduction in hours and before the end of this 18–month period:

1. you die;
2. you divorce or become legally separated; or
3. you become entitled to Medicare,

your spouse and dependent children may extend Continuation Coverage. Additionally, during this 18–month period, if a child loses dependent status, the child may also extend Continuation Coverage.

In these instances, Continuation Coverage will be extended up to 36 months from the date coverage was originally lost, subject to payment of up to 102% of the applicable group premium.

Pre–existing Medical Conditions

If your Continuation Coverage terminates because you become covered under another employer–sponsored health plan and that plan limits or reduces your coverage due to a pre–existing medical condition, you may maintain Continuation Coverage for the balance of the applicable 18 or 36 month period.

Continuation Coverage will then pay benefits for the pre–existing medical condition without regard to any other group health coverage. All other benefits will be coordinated with the new group health plan so that no more than 100% of allowable expenses under both group health plans will be payable.

Social Security Disability

If you, your spouse or a dependent child are disabled at the time of termination in your employment or reduction in hours or within 60 days of the commencement of Continuation Coverage, the disabled person and any other covered family member(s) may be entitled to 29 months of Continuation Coverage instead of 18 months.

To qualify for this extension, the disabled person must be determined to be disabled under the Social Security Act and notify the Plan Administrator when a written determination of disability is received from Social Security. This notice must be provided to the Plan Administrator within 60 days after the date of determination and prior to the end of the 18 month continuation period.

The disabled person must also notify the Plan Administrator within 30 days of the date the Social Security Administration determines that he or she is no longer disabled. This extended Continuation Coverage will then terminate on the first day of the month which begins after the expiration of such 30 day period.

For the first 18 months of Continuation Coverage the plan requires payment of up to 102% of the applicable group premium. For the next 11 months the plan may require payment of up to 150% of the applicable group premium.

State Continuation Rights

Several, but not all states, have continuation options from which you may choose as an alternative to Continuation Coverage. Unless otherwise provided in your booklet, you may elect either the State Continuation or Continuation Coverage but you cannot elect both.

If you have any questions concerning Continuation Coverage or a state option, your employer will be able to provide you with the information you need. Your employer will also have the necessary forms needed to continue your coverage. Also, if you have a change in marital status or you or your spouse change addresses, please notify your employer.

This Summary is intended to provide you with a brief explanation of COBRA. It is not intended to provide you with legal advice.