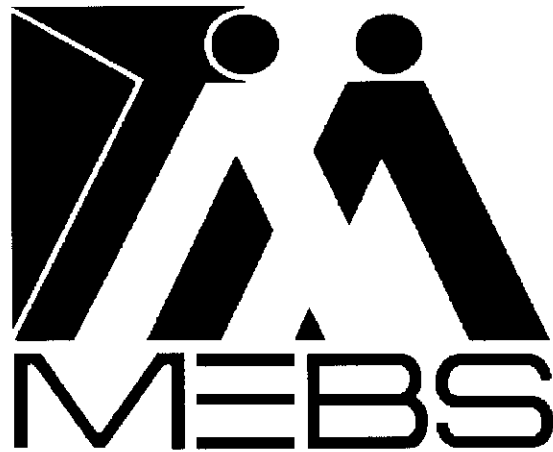


MICHIGAN EMPLOYEE BENEFIT SERVICES



SELF FUNDED VISION
FOR

BAY ARENAC ISD

Bay Arenac Education Association

Effective: November 1, 1997

**SELF FUNDED
VISION BENEFIT COVERAGE SCHEDULE**

Employer: Bay Arenac ISD
4228-2 Mile Rd.
Bay City, MI 48706-2397
(517)686-4410

Group Number: 04-0009
Effective: November 1, 1997

Eligible Class(es): Bay Arenac Education Association

Service Requirement: None

Min. Work Requirement: 20 hours per week

Employee Contributions: None

Annual Open Enrollment Period: Month of September

Benefit Period: January 1 thru December 31.

Coordination of Benefits: Standard

Assignment of Benefits: Yes

Plan Year: The records of the Plan are kept separately for each Plan Year.
The Plan Year begins on July 1 and ends on June 30.

SCHEDULE OF BENEFITS

Complete Vision Examination (Maximum Allowed)	\$48.00
Single Vision Prescription (Maximum per Pair of Lenses)	63.00
Bifocal Prescription (Maximum per Pair of Lenses)	72.00
Trifocal Prescription (Maximum per Pair of Lenses)	90.00
Lenticular Prescription (Maximum per Pair of Lenses)	108.00
Frames (Maximum per Standard Set)	50.00
Contact Lens Prescription (Maximum per Pair of Lenses)	150.00
Eye exam paid separately	

BENEFIT SERVICE FREQUENCY

Vision Examination:	Once every Benefit Period
Lenses:	Once every Benefit Period
Frames:	Once every Benefit Period

MICHIGAN STATE AFL-CIO PUBLIC EMPLOYEE TRUST
TRUST VISION ALTERNATIVE CARE PLAN

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IMPORTANT NOTICE: Federal law requires every welfare benefit plan to notify each covered employee Member and dependent(s) of their continuation of coverage rights after termination of employment. Your rights regarding continuation of coverage are described in Section III of this booklet.

INTRODUCTION TO THIS PLAN DESCRIPTION

TO PARTICIPATING MEMBERS:

We are pleased to provide you with this description of the Michigan State AFL-CIO Public Employee Trust Vision Care Plan Alternatives (the "Plan"). The purpose of this booklet is to set forth the material terms of the Plan. This booklet contains the Plan as effective on July 1, 1990. The Plan is administered by the Board of Trustees of the Michigan State AFL-CIO Public Employee Trust Fund (the "Fund"), and is subject to the Trust Agreement establishing the Fund and applicable rules, regulations and policies of the Fund, which are incorporated herein by reference. Only the full Board of Trustees is authorized to interpret the Plan. No employer of union, or any representative of an employer or union, is authorized to interpret the Plan. The Board of Trustees of the Fund, or its designated administrator, shall be the sole judge of the standard of proof required in any case, and in the application and interpretation of any of the provisions of the Plan, the decisions of the Trustees and its administrator shall be final and binding on all parties or persons affected. You may obtain additional information about the Plan and examine all related documents, including the Trust Agreement of the Fund by contacting the Benefit Administrator during normal business hours at the following address and telephone number:

Michigan Employee Benefit Services, Inc. (MEBS)
25 Jefferson Ave.
Jefferson Place
Grand Rapids, Michigan 49503
www.mebs.com

(616) 458-6327

The Plan and the Trust Agreement and/or Insurance Policies under which this booklet is issued, may be amended or discontinued at any time by the Board of Trustees.

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

Board of Trustees

<u>Trustee</u>	<u>Union</u>
Mr. Frank Garrison	Michigan State AFL-CIO
Mr. Al Garrett	American Federation of State, County, and Municipal Employees (AFSCME)
Mr. Philip Schloop	International Union of Operating Engineers
Mr. Rollie Hopgood	Michigan Federation of Teachers (MFT)
Mr. Paul Policicchio	Service Employees International Union (SEIU)

The Vision Plan in this booklet is Underwritten by:

Associated Mutual Hospital Service Company of Michigan
25 Jefferson Place, S.E.
Grand Rapids, MI 49503

No policy limitation and/or condition is waived or modified by reason of omission from this booklet.

SECTION I

Important Definitions and Terms

The following terms are used throughout this booklet:

- 1.01 The term "Actively at Work" shall mean a Member must be on the job and physically able (other than absences due to a medical condition or medical treatment) to perform his/her regular full time duties for a regularly scheduled work day. Each Employer may establish a minimum work requirement, consisting of a number of hours which must be worked per week, for its employees to be considered Actively at Work. The number of hours which must be worked per week, if any, in order to meet the minimum work requirement is shown in the Coverage Schedule on the inside front cover of this booklet.
- 1.02 The term "Benefit Determination Period" shall mean that period of time or the frequency of services which are provided to each Member covered by this Plan as indicated on the Coverage Schedule found inside the front cover of this booklet.
- 1.03 The term "Benefit Administrator" shall mean Michigan Employee Benefit Services, Inc. (MEBS), 25 Jefferson Ave., Jefferson Place, Grand Rapids, Michigan 49503), telephone (800) 968-6327, internet address: www.mebs.com.
- 1.04 The term "Complete Vision Examination" shall mean a vision examination including an eye examination, refraction, case history, examination for disease or pathological abnormalities of eyes and lids, ranges of clear single vision and balance and coordination of muscles for far seeing, near seeing and special working distances analysis, and professional consultation.
- 1.05 The term "Dependent" shall mean an employee Member's spouse while not divorced or legally separated from the employee Member; and each of the employee Member's unmarried children who can be declared as a dependent on the employee Member's federal tax returns under the Internal Revenue Code of the United States. Eligibility for continuation of coverage for a divorced or legally separated spouse is further provided and defined in Section 3.02 of this document. Dependent eligibility and limiting age of dependents is defined in Section 2.03. An employee Member's children shall include stepchildren, legally adopted children, and any other children receiving coverage pursuant to a Qualified Medical Child Support Order.
- 1.06 The term "Effective Date" shall mean this Plan's effective date for an employer pursuant to a collective bargaining agreement. An employee's "Effective Date" shall be that date this Plan's benefits become effective.
- 1.07 The term "Employee" shall mean an employee who works for an Employer.
- 1.08 The term "Employer" shall mean an Employer who is participating in the Plan pursuant to a collective bargaining agreement, or other agreement approved by the Board of Trustees of the Trust Fund, and who has signed a participation agreement with the Fund.
- 1.09 The term "Fund" shall mean the Michigan State AFL-CIO Public Employee Trust Fund (PET).
- 1.10 The term "Member", "Employee Member", or "Covered Member" shall mean an employee who has met the eligibility requirements for coverage under the Plan; "Member" shall also mean, where applicable, a Dependent covered under the Plan by virtue of a relationship to an employee Member.

- 1.11 The term "Plan" shall mean this Michigan State AFL-CIO Public Employee Trust Vision Care Plan. The term "Other Plan" shall mean any plan provided by any employer or any other plan required by law that provides vision care benefits or services under:
- (a) Group coverage or any other insured or uninsured arrangement of coverage for which any employer contributes all or part of the cost, and/or makes payroll deductions; or
 - (b) Basic automobile reparations (no-fault) coverage, but only to the extent of the benefits required by, or available under the applicable no-fault law, and if such no-fault coverage does not, under its rules, determine its benefits after the benefits of any group health, dental, and/or vision coverage.
- Benefits payable under another plan include the benefits that would have been payable if a benefit request had been made for them.
- 1.12 The term "Plan Administrator" shall mean the Board of Trustees of the Fund. The Trustees have contracted with Michigan Employee Benefit Services, Inc. (MEBS) (the "Benefit Administrator") to provide billing, benefit, claims administration, and administrative services.
- 1.13 The term "Plan Year" shall mean that period from July First (1st) through June Thirtieth (30th) of each year.
- 1.14 The term "Provider" shall mean any duly licensed provider of vision care services practicing within the scope of his profession and any other Physician furnishing any vision services which he is licensed to perform.
- 1.15 The term "Service Requirement" shall mean the amount of continuous employed time an employee Member must be in active employment in a covered classification with a participating Employer before the employee can become eligible for coverage under this Plan, The Service Requirement for this group is listed in the inside front cover of the booklet.
- 1.16 The term "Vision Treatment Plan" shall mean a Vision Provider's report, on a form satisfactory to the Benefit Administrator, which:
- (a) Itemizes the vision services recommended by him for the necessary vision care of the Covered Member, and
 - (b) Shows his charge(s) for each vision service(s) provided.
- 1.17 Whenever used herein, a masculine noun or pronoun is deemed to include the feminine, and a singular noun or pronoun is deemed to include the plural unless the text involved indicates to the contrary.

SECTION II.

ELIGIBILITY FOR MEMBERSHIP

2.01 Initial Employee Eligibility

- (a) In cases where the Employer pays the full cost of coverage, an employee shall be eligible for coverage as a Member under the Plan provided he meets all of the following conditions.
- (i) The Plan is in effect for his Employer; and
 - (ii) The employee is included in a class of employees which is eligible for coverage under the Plan pursuant to a participation agreement; and
 - (iii) The employee is Actively At Work and meets any applicable minimum hours per week requirement; and
 - (iv) The employee has satisfied the applicable required Service Requirement.

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

- (b) In cases where the employee contributes toward the cost of coverage, an Employee shall be eligible for coverage as a Member under the Plan provided he has met all of the requirements in paragraph (a) above (subparagraphs i, ii, iii, and iv), and he has completed an enrollment form and authorized his Employer in writing to deduct the required contribution amount from his payroll checks for a period of twelve (12) months. Employees who do not complete a written enrollment and authorization for payroll deduction within thirty-one (31) days after the date of initial eligibility (as defined in paragraph (a) above) may not enroll for coverage in the Plan until the next following Open Enrollment or succeeding Open Enrollment thereafter. Written enrollment and authorization for payroll deduction is irrevocable for a period of twelve (12) months (subject to changes on family status which may be made at Open Enrollment, as described in Section 2.04).

2.02 Effective Date of Coverage

An Employee's effective date of coverage will be the first day of the month following the date all the conditions in subsection 2.01 above have been met.

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

IMPORTANT NOTE: Employees must submit a completed enrollment form to the Benefit Administrator within thirty-one (31) days of the initial eligibility date for coverage. Prior to the payment of any claims, the Member must have submitted a completed enrollment form to the Benefit Administrator.

2.03 Dependent Eligibility

- (a) If an employee Member is included in a class of employees for which dependent coverage applies, eligible Dependents of that employee shall, on the date the employee becomes a Member, become covered Members under the Plan, effective as of the date the employee becomes a covered Member under the Plan as described in Subsection (2.02).
- (b) An employee Member's Dependent Child(ren) can be covered beyond the end of the calendar year of the Dependent child's nineteenth (19th) birthday. Coverage for Dependent Children can be continued up to the end of the calendar year of the twenty-fifth (25th) birthday, provided all of the following conditions are met:

- (i) they are unmarried; and
 - (ii) they are dependent upon the Member for more than one-half of their financial support and can be declared as a dependent on the employee Member's federal tax return under the Internal Revenue code of the United States; and
 - (iii) they reside with the Member, or are in temporary residence at school or camp; and,
 - (iv) all required monthly contributions are made timely on their behalf.
- (c) If a Dependent Child is or becomes incapacitated due to a physical handicap or mental retardation while covered under the Plan, such child will continue to be considered a Dependent Child provided satisfactory proof of the child's incapacity is submitted to the Benefit Administrator within thirty (30) days following the end of the year in which the child would otherwise cease to qualify as a Dependent child, and proof of the continuation of the incapacity is submitted to the Benefit Administrator once each year thereafter provided the Covered Member pays the appropriate monthly contribution.

2.04 Change(s) In Coverage /Open Enrollment

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

- (a) Family Status changes, such as addition or deletion of a spouse or Dependents must be made within thirty-one (31) days of the date the change in family status occurred, Otherwise, Family Status changes may be made at the next following Open Enrollment.
As change in family status should be reported to the Employer or the Benefit Administrator.
- (b) If a Member's Spouse or Dependent is covered under an Other Plan, and that Other Plan coverage is subsequently canceled, the Spouse or Dependent may be enrolled immediately in this Plan at the time the Other Plan coverage terminates, provided there is no lapse in coverage between the Other Plan and this Plan.
Otherwise the Spouse or other Dependent may be enrolled at the next following Open Enrollment.
- (c) Employees who are required to contribute toward the cost of their coverage, and who have not completed enrollment and written authorization for payroll deduction within thirty-one (31) days after they initially become eligible for coverage, may enroll as Members on the next following Open Enrollment or succeeding Open Enrollment thereafter, with coverage to begin effective on the first day of the month following date of enrollment.

The Open Enrollment Period for your group is indicated on the Coverage Schedule found on the inside front cover of this booklet.

2.05 Termination of Membership

Once a Member is initially eligible for coverage under the Plan, his coverage will continue until it is terminated, Termination of coverage will be effective on the first occurring of any of the following dates:

- (a) On the first day of the month for which the Employer's contributions are no longer current; provided that coverage shall be reinstated effective the first of the month for which contributions on the Member's behalf resume provided all other eligibility requirements are met; or,
- (b) On the first day of the month for which the Member's contributions (if applicable) are not current; provided that coverage may be reinstated at the next following Open Enrollment on payment of required contributions thirty (30) days in advance (and provided all other eligibility requirements are met); or,

- (c) On the first day of the month following the month in which the employee Member ceases to be a Member of the class of employees eligible for coverage because of termination of employment or for other reason; or,
- (d) On the first day of the month following the date on which the class of employees to which the employee Member belongs is no longer eligible for coverage; or,
- (e) The date on which the Plan terminates.

SECTION III.

GROUP CONTINUATION COVERAGE

3.01 This section should be read carefully by the employee Member and all covered Dependent Members:

Your vision coverage will end when you and your dependents are no longer eligible to receive benefits through your Employer.

However, under the requirement of a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, the plan makes available to you and your covered dependents the opportunity for a temporary extension of your vision care coverage in certain instances where coverage would otherwise end.

To continue this coverage (called Continuation Coverage), you or the affected Dependent will be required to pay the entire applicable Continuation Coverage cost.

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

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

(v) You cease to be a "Dependent Child" as defined under this Plan.

(d) Newborn or Adopted Child

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

(e) How Does the Election Take Place? In order to qualify for Continuation Coverage, the employee Member or a covered Dependent has the responsibility to inform MEBS (at the address found in the Introduction to this booklet) immediately after a divorce, legal separation, or if a child ceases to satisfy the definition of "dependent child" in the Plan. If you do not report one of these events to MEBS within sixty (60) days after loss of coverage due to the event, Continuation Coverage will not be available.

It is the employee/subscriber's responsibility to notify MEBS of family status changes such as employee's death, termination of employment, reduction in hours, layoff, strike, disability, medical leave of absence, retirement or entitlement to medicare, (This is called a Qualifying Event under COBRA).

Failure, on the part of the employee, to notify the Benefit office within 60 days of the Qualifying Event results in loss of COBRA qualification rights. You do not have to show that you are insurable to choose Continuation Coverage (COBRA).

An employee, spouse, or dependent who is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time of the qualifying events listed above must notify the benefit office of such determination with 60 days after the determination; in addition, the benefit office must be notified within 30 days of a determination that the employee, spouse, or dependent is no longer disabled.

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

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

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

(f) What is the Cost? You and/or your dependents must pay the entire cost of Continuation Coverage at group rates. The cost will not exceed 102% of the cost for providing benefits to individuals in the same benefits selection situation as yourself. Specific cost information will be provided to you when you become eligible for Continuation Coverage.

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

If you, as a spouse or dependent, are receiving Continuation Coverage for the eighteen (18) month period and another qualifying event occurs, e.g., divorce, legal separation, death, loss of dependent status, you are eligible to have your coverage extended to a total of thirty-six (36) months from the date of the first event qualifying you for Continuation Coverage. If the second event is the covered employee becomes entitled to Medicare, and later terminates employment or reduces hours of employment, coverage may be extended to Thirty-six (36) months from the date of entitlement to Medicare. Please be sure to contact MEBS if this occurs.

If an employee, spouse, or dependent is determined to have been disabled under Title II or Title XVI of the Federal Social Security Act at the time of termination of employment or reduction in hours causing a loss of coverage, and if MEBS is notified of such determination before the end of eighteen (18) months of Continuation Coverage, the Continuation Coverage period may be extended to twenty-nine (29) months from the date of initial eligibility or when the individual is determined no longer disabled, if earlier.

Disability After COBRA Continuation Coverage Begins

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

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

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

- (i) This Plan no longer provides group coverage;
- (ii) You do not pay your contributions for Continuation Coverage on time;
- (iii) You or an eligible dependent become covered under another employer sponsored group plan as an employee, dependent or spouse, provided that continuation will not end for an individual for so long as the coverage under another employer sponsored group plan has an exclusion or limitation with respect to any pre-existing condition of that individual which is covered under this Plan; or
- (iv) You or an eligible dependent becomes entitled to Medicare.

- 3.03 Conversion of Coverage: Continuation Coverage is not the same as **Conversion of Coverage**. This group Dental Plan does not include provisions for conversion of coverage.

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

SECTION IV.

PLAN BENEFITS

NO MEMBER SHALL HAVE ANY RIGHT OR CLAIM
TO BENEFITS EXCEPT AS SPECIFIED IN THE PLAN DOCUMENT
AND/OR APPLICABLE INSURANCE POLICIES.

4.01 Benefit Coverage

- (a) Eligible Vision Care Charges are those charges actually made to the Member, subject to limitations or exclusions provided in the Plan, for those treatment and services listed in this Plan, to the extent that such charge(s) are the usual, customary, and reasonable charges for the services performed, or materials furnished.
- (b) A charge will be considered incurred on the date of the service for which the charge is made.
- (c) The Types of Vision Services for which a Member is covered are listed on the inside front cover of this booklet. The Schedule of Covered Services set forth at the end of the booklet in Schedule A.

4.02 Co-Payments

- (a) Co-Payments: Eligible Vision Care charges are covered under the Plan up to the percentage or dollar amount specified in the Schedule of Covered Services, Schedule A located at the end of this booklet. The remaining portion of the Eligible Vision Care charge is the responsibility of the Covered Member through co-payment.

4.03 Types of Services

- (a) Complete Vision Examination Includes: A vision examination including an eye examination, refraction, case history, examination for disease or pathological abnormalities of eyes and lids, ranges of clear single vision and balance and coordination of muscles for far seeing, near seeing and special working distances analysis, and professional consultation.
- (b) Lenses and Frames Includes: Standard size lens (65mm diameter or less) including glass or plastic for single, bifocal, and trifocal lenses; tints when medically necessary and equivalent to rose #1 and #2, and standard frames (and standard size) including metal, plastic, and/or wire.
- (c) Contact Lenses Includes: Contact lenses when medically necessary are covered up to the maximum allowance percentage of the usual, customary, and reasonable fee charged by the provider. Contact lenses when not medically necessary (Cosmetic) are covered up to a maximum allowed Scheduled Benefit per pair of contact lenses, Examination and Testing Charges will be included under the Complete Vision Examination allowance. Eligible lenses include hard, soft, or extended wear lenses.

4.04 Frequency of Covered Services

Frequency of Covered Services defines the minimum amount of time which must elapse before any eligible services can again be provided by this Plan to a Covered Member. The Frequency of Covered Services or Benefit Determination Period is limited in this Plan as indicated in the Coverage Schedule found in the inside cover of this booklet.

SECTION V.

EXCLUSIONS FROM COVERAGE

5.01 Exclusions From Coverage

The Vision expenses described below are not covered under the Plan.

- (a) Treatment or services due to disease which is covered by a Workers' Compensation or Occupational Disease Law, or due to injury arising out of or in the course of any employment by the Employer or for which the individual is entitled to benefits under any Workers' Compensation Law;
- (b) Duplication or replacement of lenses or frames which have been lost, stolen, or broken (except at normal intervals when the individual would otherwise be eligible for the service or materials);
- (c) Expenses in excess of the allowed number of Complete Examinations during any one Benefit Determination period as provided in the Coverage Schedule;
- (d) Expenses in excess of the allowed number of lenses during any one Benefit Determination period as provided in the Coverage Schedule;
- (e) Expenses in excess of the allowed number of frames (sets) during any one Benefit Determination period as provided in the Coverage Schedule.
- (f) Any eye examination required by an employer as a condition of employment;
- (g) Orthoptics, vision training, subnormal vision aids, Aniseikonia lenses, or non-prescription lenses;
- (h) Tinted lenses (other than Rose #1 or #2 or light photo-chromatic lenses), unless otherwise noted in your Schedule of Benefits;
- (i) The extra cost of cosmetic lens characteristics as, but not limited to blended lenses, oversize lenses, and/or progressive lenses, unless otherwise noted in your Schedule of Benefits;
- (j) Medical or surgical treatment of the eyes;
- (k) Services and supplies for which the covered person is not required to pay;
- (l) Treatment of a condition caused by military action, or war, declared or undetected.
- (m) Charges for completion of claim forms or for missed appointments.
- (n) Services received or materials ordered before a Covered Member's effective date.

- (o) Lenses and/or frames ordered while a Covered Member, but delivered more than 30 days after termination of coverage.
- (p) Charges for services which do not meet accepted standards of ophthalmic practice, including charges for any such services or supplies which are experimental or research in nature.

5.02 Limitations On Coverage

The Plan contains the following limitations on benefits:

- (a) This plan does not cover the portion of any charge for any vision service in excess of the reasonable and customary charge. The reasonable and customary charge is the usual charge made by the provider for a like service in the absence of coverage, but not more than the prevailing charges, as determined by the Administrator for vision care of a comparable nature, made by providers of similar training and experience, within the area in which the service is actually provided, "Area" means the municipality (or in the case of a large city, the subdivision thereof) in which the service is actually provided or such greater area as is necessary to obtain a representative cross section of charges for like services.
- (b) If, for any charge, a benefit amount would be provided both under this Plan and any other benefit plan of the Fund, that charge will be eligible under this Plan only to the extent necessary to provide a benefit equal to the excess, if any, of:
 - (i) The benefit that would be payable for such charge under this Plan in the absence of this limitation, over
 - (ii) The aggregate benefit payable for that charge under all other benefit plans of the Fund.

SECTION VI.

LIMITED EXTENSION OF BENEFITS DURING TREATMENT

In certain circumstances, the Plan will pay benefits for vision services rendered within thirty (30) days after a person ceases to be a covered Member. This extension of benefits is subject to all conditions, exclusions, and limitations that apply generally under the Plan, including the claim provisions. The extension of benefits applies only to Covered Services (included in the Schedule of Covered Services and applicable to the Member immediately prior to termination of coverage) performed under the following circumstances:

- (a) For those services included in the List of Vision Services which were incurred prior to the Member's termination date and delivered to the Covered Member within thirty (30) days from the Member's termination date; and
- (b) This extension will operate only to the extent that the coverage for the services is not otherwise provided to the Member through another Employer; and
- (c) The benefits of this Extension of Benefits Coverage are payable only to the Member, and all payments are subject to the Plan's Claim Provisions.

This extension of benefits under limited circumstances is independent of optional continuation of coverage on a self-pay basis after termination of Membership, which is discussed in Section III.

SECTION VII.

COORDINATION OF BENEFITS

7.01 Benefit Determination

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

7.02 Computation of Benefits

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

7.03 Order of Benefit Determination

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

- (a) Benefits of any Other Plan which does not contain a provision for coordination with other plans are determined prior to determination of any benefits of this Plan.
- (b) Primary liability rests with the plan under which the covered Member is eligible as a covered **employee**. Secondary liability rests with the plan under which the covered Member is eligible as a **dependent**. In situations where the covered Member is the employee and also is covered as an employee by an Other Plan (as defined in Section 1.22), the Order of Benefit Determination will be those rules as outlined in subsections (d) and (e).
- (c) When neither (a), nor (b) is determinative, primary coverage for a dependent child is with the plan covering the parent whose birthday occurs earlier in the calendar year. If both parents have the same birthday, the benefits of the plan which has the covered Member claiming benefits longer are determined before those of the plan which covered the covered Member for a shorter period of time. If the Other Plan does not have this rule coordination is determined under the rules of the Other Plan.

However, when the parents of a dependent child are legally separated or divorced, the following order of benefit determination applies: the Plan covering the child as a dependent of a parent who has been given financial responsibility for medical, dental, or other health care expenses of the child under a court order of decree is primary. Otherwise, the plan covering the custodial parent will be primary; where the custodial parent has remarried, coverage of the custodial parent will be primary, followed by the plan covering the child as a dependent of the custodial parent's spouse, followed by the plan of the non-custodial parent.

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

- (e) If the above rules do not establish an order of benefit determination, primary liability rests with the plan which has covered the Covered Member or Dependent continuously for the longer period of time.
- (f) Where a Covered Member is subject to certain cost containment provisions under the primary plan, any cost containment sanction(s) imposed by the primary plan will not be payable as a benefit, or a secondary balance, by any of the other secondary plan(s).

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

SECTION VIII.

CLAIM PROCEDURE AND GENERAL PROVISIONS REGARDING BENEFITS

**NO MEMBER SHALL HAVE ANY RIGHT OF CLAIM TO BENEFITS
EXCEPT A SPECIFIED IN THE PLAN DOCUMENT
AND/OR APPLICABLE INSURANCE POLICIES.**

8.01 Filing a Claim

- (a) If you have a claim, your Provider may provide you with a claim form. Otherwise, contact your Employer or the Benefit Administrator to obtain a claim form. A claim may also be submitted on a form provided by the Doctor provided the form indicates the date of service, the patient, the services rendered, and a itemization of cost for each service provided. Written proof of loss be furnished to the Benefit Administrator on an approved claim form within ninety (90) days after the date the covered expense is incurred.

Benefits will not be paid until the Benefit Administrator receives written documentation of the occurrence, nature and extent of the expense for which the claim is filed. Failure to furnish such documentation within the required time shall not invalidate nor reduce any claim if it was not reasonably possible to give documentation within such time, provided such documentation furnished as soon after as reasonably possible.

Important note regarding late claims: The Plan will not honor and no payment will be made for a claim which has not been received by the Plan within one (1) year following the end of the calendar year in which services were rendered.

- (b) The Benefit Administrator may examine the Member whose sickness or injury is the basis of the claim when and so often as it may deem necessary during pendency of the claim.

- (c) No action at law or in equity shall be brought to recover under the Plan prior to the expiration of sixty (60) days after written proof of the loss upon which claim is based has been furnished above. No such action shall be signed by the employee Member as a part of the enrollment process. Therefore, all payments will be made directly to the Provider of services, unless the covered Member notifies the Administrator in writing to make payment directly to the covered Member.
- (d) An Assignment of Benefits, authorizing the Administrator to make payment directly to the Provider, shall be signed by the employee Member as a part of the enrollment process. Therefore, all payments will be made directly to the Provider of services, unless the covered Member notifies the Administrator in writing to make payment directly to that covered Member.

8.02 Appeal of Denied Claims

Should a Member disagree with a decision of the Plan regarding benefits, the Member may file an Appeal of denied Claims. To file an Appeal of Denied Claims, a Member or his authorized representative should:

- (a) Write to the Plan listing the reasons for the appeal, and
- (b) Provide any and all facts upon which are relied on the appeal, and
- (c) Mail the Appeal of Denied Claims to:

Michigan Employee Benefit Service, Inc.
25 Jefferson Ave.
Jefferson Place
Grand Rapids, Michigan 49503
www.mebs.com

The Member must mail the appeal within sixty (60) days from the date received notice of the Plan's decision which is disputed. He, in preparing his appeal, may examine or copy Plan Documents, as described in this booklet.

The Trustees will review the appeal promptly and advise the Member of their decision in writing, setting out specific reasons for the decision and specific references to Plan Provisions on which it is based. The written decision will be issued within sixty (60) days after the appeal is received, unless special circumstances require more time for processing the appeal, in which case the Member will be so informed. In no event will the decision be issued later than one hundred-twenty (120) days after receipt of the appeal.

8.03 Workers' Compensation

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

8.04 Favorable Results of Treatment

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

8.05 Right of Recovery

If an overpayment is made due to any reason, including but not limited to payment under any workers' disability or occupational disease act or law, clerical error or misstatement of age, the Plan shall have the right to recover such overpayment from the Covered Member, or to deduct such amount of overpayment from future benefits. This provision shall be in addition to , and not in lieu of, any other remedy available to the plan at law or in equity.

8.06 Subrogation

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

8.07 Release of Information

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

SECTION IX.

PLAN ADMINISTRATION AND GENERAL INFORMATION

9.01 General Information

The Michigan State AFL-CIO Public Employee Trust ("Plan") is an employee beneficiary association established exclusively to provide health benefits and other related benefits to its Members and their families. The Plan is established, maintained, and sponsored by the Michigan State AFL-Cio, American Federation of State, County, and Municipal Employees AFSCME) council 25, the Michigan Federation of Teachers (MFT), Service Employees International Union (SEIU) Local 79, and the International Union of Operating Engineers (IUOE) Local 547 (together called the "Sponsoring Unions").

The following information concerning this Plan is provided in accordance with government regulations:

(a) **Name of Plan:**

MICHIGAN STATE AFL-CIO PUBLIC EMPLOYEE TRUST
TRUST VISION ALTERNATIVE CARE PLAN

(B) Plan Administrator and Fiduciary:

Board of Trustees of the Michigan State AFL-CIO Public Employee Trust. As of January 1, 1999, the Trustees of the Plan are:

<u>Name</u>	<u>Union</u>	<u>Address</u>
Mr. Frank Garrison	AFL-CIO	419 South Washington Lansing, MI 48933
Mr. Al Garrett	AFSCME	1034 North Washington Lansing, MI 48906
Mr. Phillip Schloop	IUOE	24270 W. 7-Mile Rd. Detroit, MI 48219
Mr. Rollie Hopgood	MFT	2661 E. Jefferson Detroit, MI 48207
Mr. Paul Policicchio	SEIU	2604 Fourth St. Detroit, MI 48201

(c) Benefit Administrator:

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

Michigan Employee Benefits Services, Inc. (MEBS)
25 Jefferson Ave.
Jefferson Place
Grand Rapids, Michigan 49503
www.mebs.com

Telephone number: (800)968-6327
www.custserv@mebs.com

The Benefit Administrator:

- (i) Does not guarantee or warrant this is an insured plan. The Fund assumes all responsibilities for insuring benefits on behalf of Members covered by the plan(s).
- (ii) Does not insure, reinsure, or fund this benefit plan. Should the Plan Sponsor elect not to reinsure this plan, and ultimately not pay (fund) benefit expenses which are eligible for payment under the plan for any reason, the Members covered by the plan may be liable for those expense.
- (iii) Merely processes claims and does not insure the eligible expenses of the Plan. The Administrator does not guarantee Members covered under the plan that eligible expenses will be paid.
- (iv) Will promptly process complete and proper claims submissions for benefits made by Members covered by the plan. In the event there are delays in processing claims, the Members covered by this plan shall have no greater rights to interest or other remedies against the Benefit Administrator than as otherwise afforded by law.

(b) **Fund Identification Number:**

The Fund has been assigned the following employer identification number by the Internal Revenue Service: 38-2750682.

(e) **Plan Year:**

The Plan's fiscal records are maintained on a plan year basis from July first (1st) through June thirtieth (30th).

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

Mr. Andrew Nickelhoff, Esq., Fund Counsel
Sachs, Waldman, O'Hare, Helveston,
Bogas & McIntosh, P.C.
1000 Farmer
Detroit, Mi 48226

9.02 Source of Contribution

This Plan is funded through a trust fund, the Michigan State AFL-CIO Public Employee Trust Fund, which is established and maintained for the sole purpose of providing benefits to eligible Members and their covered Dependents. The Trust Fund receives contributions from Participating Employers, and also from Members in certain circumstances. Benefits may be provided through insurance policies, and/or on a self-funded basis. Should the Plan ultimately not pay benefit expenses which are eligible for payment under this Plan for any reason, the Members covered by this plan may be liable for those expenses.

9.03 Legal Action

No legal action shall be made against the Plan prior to the expiration of Sixty (60) days of receipt of claim. No such action shall be brought after the expiration of three years of receipt of claim.

9.04 Questions Regarding this Plan

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

Michigan Employee Benefits Service, Inc.(MEBS)
25 Jefferson Ave.
Jefferson Place
Grand Rapids, Michigan 49503
www.mebs.com

Telephone Number: (800)968-6327
www.custserv@mebs.com

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

9.05 Member Responsibilities

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

- (a) When you write to the MEBS Office, please be sure to provide your name and Social Security number in your letter.
If you call, please be sure to have your Social Security number handy.
- (b) Notify your Employer, and the MEBS Office within 30 days after the date you gain or lose a Dependent (spouse or child) for any reason whatever, for example, due to a divorce, separation, death, or age.
- (c) If you or one of your Dependents becomes eligible for Social Security benefits and/or Medicare coverage, you must send a copy of the Social Security Award Letter and/or Medicare Card to your employer and the MEBS Office immediately.
- (d) Notify the MEBS Office immediately if you change your home address.

9.06 Amendment of Termination of the Plan

The Board of Trustees may amend the Plan at any time. Although the Trustees anticipate that the Plan will remain in effect, they reserve the right to terminate this Plan at any time. Any funds remaining in the Plan at termination will be distributed for the benefit of Members in a manner determined by Trustees.

SCHEDULE A

SCHEDULE OF COVERED SERVICES

This Schedule of Covered Services applies to a Member's coverage under the Plan when so indicated in the Coverage Schedule as set forth in the inside cover of this booklet.

ELIGIBLE VISION SERVICES

The following Eligible Vision Services are the only services allowed on the plan and according to the co-payment amounts as provided in the Coverage Schedule located in the front of this booklet. Any service not listed will be excluded. All eligible charges are subject to any exclusions, exception, and/or limitations as provided in the Plan. Charges that are actually made for treatment of services are further limited to the extent the such charges are Usual, Customary, Reasonable (UC&R) for the services performed or the material furnished to the Covered Member.

The Plan will provide the Covered Member with the following Vision services:

VISION EXAMINATION BENEFITS

Complete Vision Examination A Complete Vision Examination including refraction and eye examination with case history, examination for disease or pathological abnormalities of the eyes and lids, ranges of clear single vision and balance and coordination of muscles for far seeing and special working distance analysis, and professional consultation.

LENSES AND FRAME BENEFITS

Single Vision Lens Prescription: Either a single lens, or a pair of lenses with a prescription.

Bifocal Lens Prescription: Either a single lens, or a pair of lenses with a prescription.

Trifocal Lens Prescription: Either a single lens, or a pair of lenses with a prescription.

Lenticular Lens Prescription: Either a single lens, or a pair of lenses with a prescription.

Standardize Frame: A Standard Type Lens Frame.

CONTACT LENS BENEFITS

Contact Lens Prescription: Either a single contact lens, or a pair of contact lenses with a prescription after cataract surgery or when visual acuity is not correctable to 20/70 in the better eye except by their use. Charges for the Complete Examination and testing are included in the Complete Vision Examination Allowance as provided in the Coverage Schedule when such lenses are not medically necessary.

FREQUENCY OF COVERED SERVICES

Benefits will not be provided more frequently than once in any twelve (12) month period beginning from the last date vision service(s) were provided to the Covered Member.