

UNIVERSITY OF MISSOURI

Vision Benefit Plan

Effective January 1, 2007



This booklet is designed to provide an overview of the Vision Benefit Plan. While the University hopes to offer participation in this plan indefinitely, it has the right to amend or terminate any benefit plan. In addition to this booklet, the University plans to continue to use other methods of communication such as memos, meetings or newsletter articles to help you stay informed.

It's important for you to have a good understanding of all this plan has to offer. Please review this booklet carefully. If you have questions, contact your Campus Benefits Representative at the appropriate address or phone number shown below.

Columbia Campus

Faculty & Staff Benefits
201 S. 7th Street
114 Heinkel Building
Columbia, MO 65211-1330
(573) 882-2146 (Active Employees)
FAX (573) 882-9603
benefits@umsystem.edu

Retirees

Faculty & Staff Benefits
201 S. 7th Street
114 Heinkel Building
Columbia, MO 65211-1330
(573) 882-9810 or 800-488-5288 (Retirees)
FAX (573) 882-9603
retirement@umsystem.edu

Hospital

Office Location: Human Resource Dept.
2401 LeMone Industrial Dr.
U.S. Mail Address: One Hospital Drive
Human Resource Dept.
QD 236
Columbia, MO 65212
Campus Mail: DC230.00
(573) 882-9086 FAX (573) 884-7107
benefits@umsystem.edu

Kansas City Campus

U.S. Mail Address: Human Resource Dept.
226 Admin. Center
5200 Rockhill Road
Kansas City, MO 64110
Office Location: Univ of Missouri- Kansas City
Human Resource Dept.
226 Admin. Center
5115 Oak Street
Kansas City, MO 64112
(816) 235-1622 FAX (816) 235-5515
benefits@umkc.edu

Rolla Campus

Human Resource Services
113 University Center East
11th and Rolla Streets
Rolla, MO 65409-1050
(573) 341-4241 FAX (573) 341-4984
benefits@umr.edu

St. Louis Campus

Office Location: Human Resource Dept.
211 General Services Bldg.
U.S. Mail Address: Univ of Missouri-St. Louis
Mark Twain Drive
211 General Services Bldg.
One University Blvd.
St. Louis, MO 63121
(314) 516-5639 FAX (314) 516-6463
joann_westbrook@umsl.edu

Faculty & Staff Benefits Department Webpage:

<http://www.umsystem.edu/ums/departments/hr/benefits>

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Introduction

The Vision Benefit Plan is designed to help you meet vision care expenses and to encourage you to include eyecare as part of your regular healthcare routine. You may select from either the Full Service Plan or the Discount Plan.

The plan provides payment for covered vision expenses for you and your eligible dependents. The plan offers specific coverage with designated copay and allowance amounts for materials and services obtained from VSP providers. The plan does give allowances when you obtain services and materials from non-network providers.

Unless otherwise stated the rules apply to retirees where employees are mentioned.

Benefit Summary – Signature Choice Full Service Plan

Benefit	Frequency	Network	Non-Network
Examinations	Once per calendar year	\$10 copayment	Reimbursed up to \$45 after \$10 copayment
Materials			
One copay of \$25 applies when both lenses and frames are purchased.			
Lenses			
Only one type of lens will be covered every 12 months.			
Single vision Lenses	Once per calendar year	\$25.00 copayment	Reimbursed up to \$45 after \$25 copayment
Bifocal Lenses	Once per calendar year	\$25.00 copayment	Reimbursed up to \$65 after \$25 copayment
Trifocal Lenses	Once per calendar year	\$25.00 copayment	Reimbursed up to \$85 after \$25 copayment
Lenticular Lenses	Once per calendar year	\$25.00 copayment	Reimbursed up to \$125 after \$25 copayment
Polycarbonate lenses are provided for dependent children at no additional cost			
Frames	Once every other calendar year (Limit of \$130)	\$25.00 copayment	Reimbursed up to \$47 after \$25 copayment
Contact Lenses (in lieu of lenses and a frame)			
Elective	Once per calendar year (Up to \$130) Include lens, fitting and contact evaluation exam.*	No copayment	Reimbursed up to \$105
Medically Necessary (requires prior approval)	Once per calendar year (covered in full) Include lens, fitting and contact evaluation exam.*	No copayment	Reimbursed up to \$210

*The contact evaluation exam is in addition to the vision exam.

EXTRA DISCOUNTS AND SAVINGS

VSP offers discounts for members enrolled in the Full Service Plan.

Laser vision correction discounts are available through contracted laser centers.

Prescription Glasses

- Up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives
- 20% off additional prescription glasses and sunglasses*

Contacts

- Exclusive pricing on annual supplies of popular brands
- 15% off cost of contact lens exam (fitting & evaluation)

*Available from the same VSP provider who provided your eye exam within the last 12 months.

Access to Services and Materials

To access services, you call a VSP provider to make an appointment. You will need to let the provider know that you have coverage with VSP and they will then verify your eligibility with VSP prior to your appointment. VSP does not issue identification cards. To verify eligibility, plan coverage, and obtain authorization, the provider will need the UM Peoplesoft employee identification number preceded by two 8's.

Example of identification number for VSP:

UM Peoplesoft Employee ID: 01234567

Alternate ID Number for VSP would be: 8801234567 (88+01234567)

All VSP providers do provide dispensing materials and services. You may, at your option, receive an exam from one provider and materials (frames, lenses or contacts) from another provider. You will need to make an appointment for the exam with one provider and then make another appointment for materials with the provider of choice. The VSP providers will contact VSP directly to verify the patient's eligibility, plan coverage and to obtain authorization.

Contact Lens Mail Service Program

VSP has an online service available to all eyecare doctors which allows patients to order replacement contact lenses through their provider's Web site or directly through www.Reordercontacts.com. VSP providers that offer this service are identified on the VSP online directory at www.vsp.com. VSP providers also offer direct delivery to home or office.

VSP Providers

You can access the University of Missouri network VSP providers at www.vsp.com/go/universityofmissouri
You may also call VSP at 800-877-7195 for a provider directory.

Payment for Services

Network Services

When you receive services from a VSP provider, you will only need to make your copayment unless services and materials received exceed the allowed amounts. If you exceed the allowed amounts or select optional items not covered by the plan, you will directly reimburse the provider. If the amount exceeds the allowance, there is a 20% discount on frames for the overage amount and up to 20% savings on additional lens options such as scratch resistant and anti-reflective coatings.

Optional items include but are not limited to:

- Frames that exceed the plan's allowed amount
- Tints
- Coatings
- No-line multifocal lenses

Non-Network Services

Services obtained through out-of-network providers are subject to the same copayment(s) and limitations as services through VSP doctors. Bills for services from out-of-network providers may be submitted to VSP for reimbursement up to the amounts shown in the Benefit Summary.

Benefit Summary – Discount Option

The Discount Option is only available to employees and their family if no one in the family is enrolled in the Full Service plan. Employees and their families will be automatically enrolled in the Discount Option if not enrolled in the Full Service Plan. There is no premium cost to the Discount Option. Please note that this plan is available for retirees not enrolled in the Full Service option but is not available for COBRA participants.

Exam Discount every 12 months 20% discount

Prescription Glasses Discounts every 12 months 20% discount when a complete pair of glasses is purchased.

Frame Discount every 12 months 20% discount when a complete pair of glasses is purchased.

-OR-

Contact Lens Exam Discount every 12 months 15% discount off the contact lens fitting and evaluation exam

Laser vision correction discounts are also available.

The discount option is only available from a VSP provider

Exclusions

The following services and/or materials are excluded under the Vision plan.

- Vision training
- Non-prescription (plano) lenses
- Two pairs of glasses instead of bifocals
- Replacement/repair of lost/broken lenses or frames
- Medical or surgical treatment
- Services or materials covered under worker's compensation
- Eye examinations required as a condition of employment

Claims Questions

If you do not understand or agree with the handling of your vision benefit, you should first contact VSP to discuss. If you do not agree with the coverage, you may appeal the decision per the following process:

Claim Denial Appeals: If, under the terms of the Policy, a claim is denied in whole or in part, a request may be submitted to VSP by Covered Person, or Covered Person's authorized representative, for a full review of the denial. Covered Person may designate any person, including his/her provider, as his/her authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

a) Initial Appeal: The request must be made within one hundred eighty (180) days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied, including the VSP Enrollee's name, the VSP Enrollee's Member Identification Number, the Covered Person's name and date of birth, the provider of services and the claim number. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person as follows:

1. Prior Authorization for Visually Necessary or Appropriate Services: within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person; or
2. Denied Claims for Services Rendered: within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

b) Second Level Appeal: If the Covered Person disagrees with the response to the initial appeal of the claim, the Covered Person has a right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, the Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to the Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

c) Other Remedies: When the Covered Person has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. For additional information, you may contact the U.S. Department of Labor or the state insurance regulatory agency.

Coordination of Benefits

Coordination of Benefits with Medical Plan Administrators

Your Vision Plan has a “coordination of benefits” provision; however, due to the routine vision care benefit, overlap does not occur in most cases with your medical plan. If this should occur, your VSP provider will communicate with the patient’s physician to coordinate benefits available under both the vision and medical plans.

Coordination of Benefits with Non-Medical Plans

If you are coordinating benefits with a non-medical plan, the patient must provide the VSP provider with both covered members’ names and member ID numbers.

Determining Primary and Secondary Coverage

- The plan that covers the patient as an employee is primary.
- The plan that covers the patient as a dependent is secondary.
- If the patient is a dependent child and is covered under both parent’s plans, the parent whose birth date falls first in the calendar year has the primary plan.

Coverage

The primary plan pays as if the secondary plan does not exist. If a VSP plan is the secondary plan, the patient will receive allowances (examination, lenses and frame) that will be used to pay up to, but not more than, the patient’s out-of-pocket expenses.

Options for Duplicate VSP Coverage

When a patient is covered under two VSP plans, the following options for coordinating benefits are applied:

One pair of glasses	When the patient obtains one complete pair of glasses, the VSP benefits can be coordinated to offset plan copayment(s), lens options, and/or frame coverage.
Two pairs of glasses	When the patient obtains two pairs of glasses, the secondary examination amount can be applied toward out-of-pocket expenses on both complete pairs of glasses.
Contact lenses	When the patient receives contact lenses and an eye exam, the exam can be paid using the primary benefit. The contact lens allowances under both plans and a secondary exam amount can be applied toward the contact lenses.
Contact lenses & glasses	When the patient receives a complete pair of glasses and contact lenses, the exam amount available on the secondary benefit can be applied to offset out-of-pocket expenses from the complete pair of glasses and contact lenses.

Coordination of Benefits with Out-of-Network Services

If the patient obtains services from a provider who is not part of the VSP network, the itemized bill should be sent to VSP. VSP will reimburse the eligible patient up to the contracted out-of-network allowed amount, not to exceed the actual charges.

Eligibility for Coverage

Active Employee Eligibility

If you are an active employee of the University, you are eligible for coverage, provided you also meet the following conditions:

- You are classified 75% FTE or more.
- You have an appointment duration of at least nine months.
- You are regularly scheduled to work at least 30 hours a week.

In addition, you are eligible for coverage under this plan if you are:

1. disabled and are entitled to benefits under the University's Long Term Disability Plan (or would be entitled to benefits if you were enrolled under that plan),
and
2. vested in the University of Missouri Retirement, Disability and Death Benefit Plan.

A per diem employee is excluded as an Employee under this Plan.

Retiree Eligibility

In order for University retirees to be eligible for the benefits described in this booklet, they must have:

- a. Retire(d) from the University of Missouri and immediately began to receive retirement benefits under the University of Missouri Retirement, Disability and Death Benefit Plan, Civil Service Retirement System, Federal Employees Retirement System or Missouri State Employees Retirement System,

or
- b. Terminate(d) employment with the University and be eligible *at that time* to begin receipt of retirement benefits under the University of Missouri Retirement, Disability and Death Benefit Plan, Civil Service Retirement System, Federal Employees Retirement System or Missouri State Employees Retirement System, but elect to defer receipt of their benefits to a later date

Dependent Eligibility

Your eligible dependents include your spouse and each of your unmarried natural children younger than age 19. Proof of relationship documentation is required for spouse and children to be covered. Coverage is available for dependents of a retiree provided they were eligible to be covered as a dependent under the programs immediately prior to retirement.

Children age 19 and older are also eligible for coverage if they meet one of the following requirements:

- They are unmarried, at least age 19 but less than age 23 and dependent on you or your spouse for principal support.
- They are unmarried full-time students, at least age 19 but less than age 25, enrolled in an accredited school and dependent on you or your spouse for principal support.
- They are unmarried, dependent on you because of a physical or mental disability and are incapable of self-sustaining employment prior to reaching the maximum age for coverage as a dependent. In this situation, you must notify the University and submit proof of the child's status within 31 days of the

date he or she would otherwise become ineligible. Disabled children may be covered by the plan as long as they remain incapacitated and dependent, and proof is submitted when requested.

In addition to your natural children, a child who lives with you in a parent-child relationship will be considered eligible under these conditions if he or she is placed in your home for legal adoption, or is a legally adopted child, stepchild or foster child.

For the purposes of this plan, an eligible foster child is a child for whom you or your spouse has assumed legal responsibility and control. In no event will this plan cover a child:

- Who is temporarily living in your home; or
- Who is placed in your home by a social service agency which retains control of the child; or
- Whose natural parent is in a position to exercise or share parental responsibility and control.

If you are eligible for coverage based on your employment with the University, you may be covered under your own employment or you may be covered as a dependent. You may not be covered both as a dependent and as an employee.

If you and your spouse both work for the University and you have children, only one of you may claim the children as covered dependents.

Premium Payment

The employee pays the full cost of the premium for vision coverage.

Your contribution will be made on a before-tax basis, which lowers the current income taxes you pay, unless you choose to contribute on an after-tax basis. Please note that retirees may only make premium payments on an after-tax basis. For more details about how the before-tax feature works for you, refer to your Flexible Benefits Plan booklet.

Coverage Begin Date

Employee

Coverage begins on the date of hire or the benefit eligibility date provided you submit the form within 30 days of your date of hire or eligibility date.

If you change from part-time to full-time (75% FTE or more) or from temporary to permanent status and become benefit eligible, you must enroll within 30 days of the date of your change in status.

Retiree

Coverage begins on the first of the year following the annual enrollment period.

Dependent

Dependent coverage becomes effective on the date the employee personal coverage becomes effective, provided you have completed and returned the plan enrollment form with each dependent's name and Social Security number listed. If, after your coverage becomes effective, you acquire a new dependent — by marriage, for example — you have 31 days to obtain coverage by completing the appropriate enrollment form and returning it to your Campus Benefits Representative.

In the case of an adopted child or a child placed in your home for adoption, you also have 31 days to obtain coverage from the date the child is placed in your custody.

It is your responsibility to notify the University of the addition of a dependent or of any changes in your family status. Contact your Campus Benefits Representative to obtain any necessary forms.

In instances where applications for enrollment are submitted subsequent to 31 days following the initial date of eligibility, two situations may apply.

1. If a specific premium contribution is required for coverage (i.e. coverage for other children did not already exist), coverage will become effective on the date a properly completed enrollment form (including proof of relationship) is submitted to your campus benefits representative provided it is done so within 180 days from the date the child was first eligible. If the enrollment form is submitted after 180 days, coverage will not become effective until the following January 1.
2. If a specific premium is not required for coverage (i.e. coverage already exists for other eligible dependent children), coverage will be made effective on the date the child first became eligible for coverage. However, before claims can be paid, a properly completed enrollment form (including proof of relationship) must be submitted to your Campus Benefits Representative.

Changing Coverage - Qualifying Family/Employment Status Changes

You may change your coverage level (including beginning or ending coverage or adding or dropping dependents) during the plan year only if you have a qualifying family/employment status change. Please note that retirees may not add a spouse or child dependent to the plan as a result of a family status change.

Qualifying family/employment status changes are limited to:

- marriage, divorce, legal separation or annulment
- death of a spouse
- a change in the number of dependent children as a result of birth, death, adoption or placement of a child for adoption
- the termination or commencement of employment of your spouse
- a change in your work schedule, or that of your spouse, that involves an increase or decrease in work hours, a strike, a lockout or an unpaid leave of absence
- a change in residence or worksite location of you, or your spouse
- receipt by the University of a valid Notice of Order to Enroll under Missouri law
- a change in entitlement to Medicare or Medicaid for you, your spouse or a dependent child
- a significant change in health coverage provided by your spouse's employer that affects you or your spouse
- a leave of absence under the Family and Medical Leave Act of 1993 (FMLA)

If any of these qualifying family/employment status changes occur, you may change your level of coverage provided the change is consistent with the status change itself. Contact your Campus Benefits Representative to complete the appropriate form, which must be completed and returned within 31 days of the date of the status change. After that, changes can be made only during the annual enrollment change period, except as required by the Health Insurance Portability and Accountability Act (HIPAA), described later in this section.

Benefit changes, when made within 31 days as described above, will be effective as follows:

- changes due to birth, adoption, placement of a child for adoption or death will be effective on the date of the event.
- changes resulting from all other qualifying family/employment status changes will be effective on the day the completed enrollment form is received by your Campus Benefits Representative.

Under the Health Insurance Portability and Accountability Act, you or an eligible dependent may also enroll for coverage if:

- you or an eligible dependent declined coverage under the University plan because you have other coverage;
- the other coverage ends; and
- you contact your Campus Benefits Representative and complete an enrollment form within 31 days after this event occurs.

This is called a *special enrollment period*. Coverage will be effective on the first day of the month following the date your enrollment form is received by your Campus Benefits Representative.

Coverage Termination

Your vision coverage will end on the earlier of the following dates:

- Coverage will end on the last day of the month of the employment termination
- When you are no longer eligible for coverage.
- When you cease making the required vision plan contribution.
- When the University terminates the plan.

Your dependent's coverage will terminate on the earliest of the following dates:

- When all dependent coverage under the plan terminates.
- When the individual no longer meets the plan's definition of a dependent.
- When your coverage terminates.
- When you cease making the required contribution for dependent coverage.

Coverage After Retirement

If you are eligible to receive benefits under the University Retirement Plan, or would be eligible if not covered under Civil Service Retirement or Federal Employees Retirement Plan, you and your eligible dependents may continue your coverage under the Vision Plan.

The University will advise you concerning the method and amount of any required contributions for this coverage.

Coverage after Employee Death

If you die while actively employed by the University and after becoming vested in the University Retirement Plan (completed at least 5 years of creditable service), or if you would be vested if you were covered under the University Retirement Plan instead of the Civil Service Retirement Plan or the Federal Employees Retirement Plan, your eligible spouse may continue coverage after your death. In addition, the continuation of coverage is available for your children, but only when spouse coverage is also continued. The continuation of coverage under this provision is subject to the payment of monthly contributions by the spouse. An eligible spouse, for the purposes of this provision is the spouse to whom you were married on the date of your death, provided you had been married to this spouse for at least one year preceding your death.

If you die after retirement from the University, your eligible spouse may continue coverage after your death, as described above, including coverage for your children. It is important to note, however, that the coverage for the spouse of a retiree is available only to the person to whom the retiree was married on the day preceding the date of retirement.

No continued coverage is available for children unless the spouse is also covered.

Enrollment for continued coverage must be made within 31 days after your death.

Continued coverage will terminate on the earliest of:

- The date the individual no longer meets this plan's definition of an eligible dependent.
- The date all dependent coverage is discontinued under this plan with respect to your class of eligible employees.
- The end of the period for which any required contributions have been made.

Continuation of Vision Plan Coverage (COBRA)

Federal law (Consolidated Omnibus Budget Reconciliation Act) requires the plan to offer covered employees and dependents the opportunity to continue Vision Plan coverage when it ends for certain specified reasons. The following provisions outline the requirements for continued coverage in accordance with the law. These provisions apply only to the extent that the required period of continued coverage has not already been provided under other plan provisions.

Eligibility for Continued Coverage

An employee and covered dependents may continue vision coverage for up to 18 months if coverage ends because of either a reduction in the number of hours worked or termination of employment for any reason other than gross misconduct.

Dependents may continue their vision coverage under the group plan for up to 36 months if their coverage ends for any of the following reasons:

- Divorce or legal separation from the employee.
- The death of the employee.

- The dependent child reaches the limiting age or otherwise ceases to qualify as a dependent under the plan.

These periods of continued coverage begin on the date of the event that caused loss of coverage, for instance, the date you leave the company or the date a dependent becomes ineligible.

In no event will more than a total of 36 months of continued coverage be provided to any individual, even if more than one of the above events occurs.

Continued coverage ends automatically if any of the following occur:

- The cost of continued coverage is not paid on or before the date it is due.
- An individual becomes covered under another group vision plan, unless coverage under the other plan is limited due to the individual's pre-existing condition.
- The plan terminates for all employees.
- The applicable maximum coverage period ends.

Extension of Maximum Coverage Period

Disabled individuals — An exception applies if an employee or a dependent is determined to be totally disabled during the first 60 days of continued vision coverage due to a reduction in hours worked or termination of employment. The maximum coverage period for the disabled individual will be 29 months, rather than 18 months. In order to be eligible for the extended period, the disabled individual must meet the definition of disability under the Social Security Act and notify the University during the first 18 months of continued coverage and within 60 days after the date of determination of disability has been made by Social Security. (The disabled individual is required to notify the University within 30 days after any final determination by the Social Security Administration that the individual is no longer disabled.)

Dependents of an employee entitled to Medicare — If an employee becomes entitled to Medicare, the maximum coverage period for dependents will not end until at least 36 months after the date on which the employee became entitled to Medicare.

Divorced or widowed spouses at least age 55 — Medical coverage can continue beyond the COBRA period if the continuation coverage under the plan expires when a divorced or widowed spouse is at least age 55. Coverage can continue for the spouse and eligible dependents until the spouse reaches age 65.

Application for Continued Coverage

When the Campus Benefits Representative is notified that one of these events has happened, you will be sent an election form notifying you of the conditions that apply to continued coverage.

However, in the event you become divorced or legally separated, or when your dependent child no longer qualifies as a covered dependent under the plan, you or your covered spouse or your covered child must notify the Campus Benefits Representative within 60 days. If you fail to do this, your dependent's rights to continued coverage will be forfeited.

Continued coverage is not automatic. You must submit the completed election form within 60 days from the later of the following dates:

- The date you cease to be eligible under the group plan.

- The date you receive the election form.

Cost of Continued Coverage

Any person who elects to continue coverage under the plan must pay on a monthly basis the total cost of that coverage plus any additional amount permitted by law. Your first payment for continued coverage must be made within 45 days of the date you sign the election form. Your payment must be sufficient to pay the applicable costs retroactive to the day following the event which caused coverage to end.

Benefits under Continued Coverage

Continued coverage will be exactly the same vision coverage you or your dependent would have been entitled to if your employee or his or her dependent status had not changed. Any future changes in the benefits or cost of coverage for the plan also will apply to you.

Extended Benefits

Benefits will be payable for covered expenses incurred in connection with vision services and materials which were ordered while the individual was covered under this plan if the item is finally delivered to such individual within 60 days after termination of coverage.

Confidentiality of Information

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the benefits manager.

This Plan, and the University, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the University.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact your Campus Benefits Representative. If you have questions about the privacy of your health information or wish to file a complaint under HIPAA, please contact the Privacy Officer identified in the privacy notice.