HM Life Insurance Company

120 Fifth Avenue, Fifth Avenue Place, Pittsburgh, PA 15222
1-800-328-5433

HM Life Insurance Company certifies that you will be insured under the Policy Number issued to the Policyholder named below during the time, in the manner, and for the amounts provided in the Policy.

President

POLICYHOLDER	Oakland University
POLICY EFFECTIVE DATE:	August 1, 2012
CERTIFICATE EFFECTIVE DATE:	August 1, 2012
STATE OF ISSUE:	Michigan

Your coverage under the Policy **HM Life Insurance Company** issued to the Policyholder is shown in this Certificate. If your coverage is changed by an amendment to the Policy, we will provide the Policyholder with a revised Certificate or other notice to be given to you.

PLEASE READ THIS CERTIFICATE CAREFULLY

This Certificate of Insurance has a Table of Contents to help you find specific provisions. It goes into effect, subject to its applicable terms and conditions, at 12:01 AM on the Certificate Effective Date shown above, at the Policyholder's address. The laws of the State of Issue shown above govern this Certificate.

“You" and "your" refer to the Employee; “we", "us", and "our" refer to **HM Life Insurance Company**. Other defined terms are printed with an initial capital letter.

GROUP VISION POLICY • NON-PARTICIPATING

THE POLICY PROVIDES LIMITED BENEFITS

Questions or Comments

We want to hear from you. If you have any questions about this Certificate, its benefits, the filing of claims, a complaint or a compliment, write to us at the address on the front of this Certificate. We thank you for your loyal patronage.

ADMINISTERED BY

Davis Vision, 159 Express Street, Plainview, NY 11803
For Customer Service Call: 800-328-4728

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INTRODUCTION

Subject to the terms and condition of the Policy, we agree to provide the Vision Insurance Benefits described in this Certificate in consideration of the Policyholder's remittance of the premium when due, or if you are being billed directly your payment of the required premium when due.

This Certificate is intended to be read in its entirety. In order to understand how benefits are calculated and all the conditions, exclusions and limitations applicable to its benefits, please read all the provisions in this Certificate carefully.

WAITING PERIOD

The Waiting Period is the period of time following that must elapse from the date you are hired before you or your Dependents are eligible for a benefit payment under the Policy. This period is determined by the Policyholder's personnel practices. We will not pay benefits services, supplies or a treatment received during the Waiting Period.

If your coverage ends you may have to satisfy a new waiting period in order to become insured again under the Policy. See *Reinstatement* for exceptions.

MEMBERS

Employee
Partner
Children
Retirees

SCHEDULE OF BENEFITS

Benefits are payable per Member. No benefits are payable for any Member until you have completed the Waiting Period.

A Member may use the Provider of their choice. There are two types of Providers - those that are part of the Network (In-Network Providers) and those that are not part of the Network (Out-of-Network Providers).

When services or materials are received from a Provider who is part of the Network, you are responsible for:

1. The Copayment, if a cash payment is due the Provider; or

2. The difference between the Allowance plus any negotiated Discount and the Scheduled Fee - we will pay the dollar amount of the Allowance, or the Provider's actual charge, if less; or

3. The difference between any Negotiated Discount and the Scheduled Fee.

Benefits for services or materials received from a Provider outside of the Network are shown in terms of the dollar amount we will reimburse you for that service or material, not the total amount you are responsible for. If you use an Out-of-Network Provider your total responsibility is the difference between the Reimbursement and the total amount charged by the Provider-we will pay the dollar amount of the Reimbursement for that service or material or the Provider's actual charge if less.

You will not be paid a separate benefit, charged an additional Copayment or incur any additional cost for any Covered Service listed as "Included".

If a Covered Expense is not available through an In-Network Provider within 50 miles of your residence, any Covered Expense incurred from an Out-of-Network Provider will be reimbursed as though they were received from an In-Network Provider.

Fashion Value Plan	Frequency
Exam	Once every 12 months
Eyeglasses (frames and spectacle lenses)	
Spectacle Lenses	Once every 24 months
Frame	Once every 24 months
Contact Lenses (in lieu of Eyeglasses)	Once every 24 months

*****Members will be entitled to new lenses with a prescription charge of .50 diopter or more every 12 months

Covered Service	In-Network Benefits
Exam	Paid in Full
Eyeglasses	
Frames	
Collection Frame (in lieu of Allowance and Discount for a Non-Collection Frame)	
Fashion Frame Collection	Included
Designer Frame Collection	$15 Copayment
Premier Frame Collection	$40 Copayment
Non-Collection Frame	$75 Allowance plus an additional 20% Discount on any overage
Spectacle Lenses (per pair)	
Single Vision Lenses	Paid in Full
Bifocal Lenses	Paid in Full
Trifocal Lenses	Paid in Full
Lenticular Lenses	Paid in Full
Contact Lenses (per pair)	
Collection Contact Lenses (in lieu of Allowance and Discount for Non-Collection Contact Lens)	Not Applicable
Non-Collection Contact Lenses	$105 Allowance plus an additional 15% Discount on any overage
Medically Necessary Contact Lenses (with prior approval)	Paid in Full
Contact lens evaluation, fitting services, follow-up care	15% Discount
All Ranges of Prescriptions and sizes	Included
Plastic Lenses	Included
Oversize Lenses	Included

There is an additional cost for the following Lens Options; other lens options, powers and frames may require an additional cost.

Lens Options (per pair)	.
Fashion and gradient tinting of plastic lenses	Included
Ultraviolet Coating	$15 Copayment
Scratch Resistant Coating	Included
Polycarbonate Lenses	Either Paid in Full or $35 Copayment
Intermediate Vision Lenses	$30 Copayment
Standard Progressive Lenses	Included
Premium Progressive Lenses	$40 Copayment
Plastic Photosensitive Lenses	$70 Copayment
Polarized Lenses	$75 Copayment
Standard Anti-Reflective (AR) Coating	$40 Copayment
Premium Anti-Reflective (AR) Coating	$55 Copayment
Ultra Anti-Reflective (AR) Coating	$69 Copayment
Hi-Index Lenses	$60 Copayment
Scratch Protection Plan – Single Vision Lenses	$20 Copayment
Scratch Protection Plan – Multifocal Vision Lenses	$40 Copayment

Covered Service	**Out-of-Network Benefits**
Exam	$30 Reimbursement
Eyeglasses	
Frames	$30 Reimbursement
Spectacle Lenses (per pair)	
Single Vision Lenses	$25 Reimbursement
Bifocal Lenses	$35 Reimbursement
Trifocal Lenses	$45 Reimbursement
Lenticular Lenses	$60 Reimbursement
Contact Lenses (per pair – in lieu of eyeglasses)	
Soft, Standard, Daily Wear, Disposable, Planned Replacement and Specialty	$75 Reimbursement
Medically Necessary Contact Lenses (with prior approval)	$225 Reimbursement
Contact lens evaluation, fitting and follow-up care	Not Applicable

Polycarbonate lenses are Covered in full for dependent children, monocular patients, and patients with prescriptions $\geq$ + 6.00 diopters.

Exam or Eye Examination includes (but is not limited to)-

- Case history - chief complaint, eye and vision history, medical history;
- Entrance distance acuities;
- External ocular evaluation including slit lamp examination;
- Internal ocular examination;
- Tonometry;
- Distance refraction - objective and subjective;
- Binocular coordination and ocular motility evaluation;
- Evaluation of pupillary function;
- Biomicroscopy;
- Gross visual fields;
- Assessment and plan;
- Advising the Member on matters pertaining to vision care;
- Form completion - school, motor vehicle, etc.; and

- A Dilated Fundus Examination (DFE) (diagnostic procedure used in the detection and management of diabetes, glaucoma, hypertension and other ocular and/or systemic diseases) when Professionally indicated.

In-Network Providers that do not display the frame Collection available will apply the Allowance towards non-collection frame.

Specialty Contact Lenses are limited to one pair of lenses. These lenses include (but are not limited to) toric, rigid gas permeable and multifocal lenses.

Medically necessary contact lenses are subject to prior approval and are limited to one pair of lenses per Frequency of Use Period unless a subsequent eye examination shows a prescription change that qualifies for another lens or lenses due to medical necessity. You or your attending Provider must send a completed request to the Administrator for medically necessary contact lenses before the lenses are dispensed initially or due to a change in prescription. Any amount due over an Allowance for such lenses is the Member's responsibility. If you do not obtain approval for medically necessary contact lenses initially or due to a prescription change the entire charge is your responsibility. This limitation will not apply if it is shown that it was not reasonably possible to submit the request for approval.

Contact lens evaluation, fitting and follow-up care applies to standard daily wear, disposable, planned replacement, specialty and medically necessary contact lens.

Low Vision Coverage

Covered Service	**In-Network**	**Out-of-Network**
Comprehensive Evaluation		
Frequency	One comprehensive evaluation every 60 months (includes four follow-up visits in that period)	One comprehensive evaluation every 60 months (includes four follow-up visits in that period)
Maximum per Evaluation	$300 Allowance	$300 Reimbursement
Maximum per Follow-up Visit	$100 Allowance	$100 Reimbursement
Maximum per Aid	$600 Allowance	$600 Reimbursement
Lifetime Maximum for all Aids	$1200 Allowance	$1200 Reimbursement

Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low-vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the Member's remaining useable vision.

A comprehensive low vision evaluation is performed in addition to an eye examination when the eye examination indicates a need for such an evaluation. This supplemental evaluation includes a history of functional difficulties that involves daily activities. The result of this evaluation may include prescription of various treatment options, including low vision aids, as well as assist the Member with identifying other resources for vision and lifestyle rehabilitation.

The Low Vision Program is subject to prior approval. The Member or the attending Provider must send a completed request to the Administrator prior to the initial evaluation. Once approved, a Member is eligible for a comprehensive low vision evaluation and four follow-up visits every 60 months up to the maximum for such evaluation and visits shown above. Low vision aids will be provided as prescribed up to the maximum per aid, subject to the lifetime maximum for all aids shown above.

If the required approval is not obtained, no benefits will be paid for any such evaluation, follow-up visits or aids and the entire charge for such services or supplies will be the Member's responsibility. This limitation will not apply if it is shown that it was not reasonably possible to submit the request for approval.

Laser Vision Correction

Covered Service	In-Network Benefits
Discount	$500 or the Provider's actual charge if less The Allowance is for both eyes and is the maximum that will be paid for laser vision correction in a Member's lifetime.

Out-of Network	Member is responsible for the entire cost

Laser vision correction is a surgical procedure to correct vision problems such as nearsightedness, farsightedness and astigmatism. Such procedures include Laser Epithelial Keratomileusis (LASEK), Laser In Situ Keratomileusis) LASIK and Photorefractive Keratectomy (PRK).

Prior approval must be obtained prior to surgery; the Member or the attending Provider must send a completed request to the Administrator prior to the initial evaluation. If the required approval is not obtained the entire charge for such services will be the Member's responsibility.

The surgery must be performed within six months of the preoperative examination. If a Member does not obtain the surgery within this time period and another pre-operative examination is necessary the cost of that examination is his responsibility.

Replacement Contact Lens Program
A Member is eligible for Davis Vision's contact lens replacement program. This mail-order program, Lens 1-2-3!®, provides a discount on contact lens replacement materials. To take advantage of this service either call 1-800-LENS123 or visit www.lens123.com with a current prescription.

In-Network Providers that do not display the frame Collection available will apply the Allowance towards non-collection frame.

Medically necessary contact lenses are subject to prior approval and are limited to one pair of lenses per Frequency of Use Period unless a subsequent eye examination shows a prescription change that qualifies for another lens or lenses due to medical necessity. You or your attending Provider must send a completed request to the Administrator for medically necessary contact lenses before the lenses are dispensed initially or due to a change in prescription. Any amount due over an Allowance for such lenses is the Member's responsibility. If you do not obtain approval for medically necessary contact lenses initially or due to a prescription change the entire charge is your responsibility. This limitation will not apply if it is shown that it was not reasonably possible to submit the request for approval.

Ancillary Product Discount
A Member will receive up to a 20% courtesy discount from most In-Network Providers. This discount applies to the purchase of items that the Policy either does not cover or which you are currently not eligible for.

DEFINITIONS

Please note that certain words used in this certificate have specific meanings. Other than references to he, him, his, you, your, yours, we, us or our, the words defined below and capitalized within the text of this Certificate have the meanings set forth below.

Allowance means a flat dollar amount payable under the Policy towards a Covered Expense from an In-Network Provider. Allowances are shown in the *Schedule of Benefits*. If the Providers charge is less than the Allowance we will only pay up to the Providers charge.

Child or Children means your, or your Partner's, unmarried natural or unmarried step Child who is under age 26.

If your Child becomes incapable of self-support due to a developmental disability or physical handicap before reaching the limiting age his coverage may be continued. To continue the Child's coverage we must receive proof of incapacity within 31 days after coverage would otherwise terminate.

This Insurance will continue for as long as the Employee's Insurance stays in force and the Child remains incapacitated. Additional proof may be required from time to time but not more often than once a year.

This term includes a Child who:

1. Is living with you or your Partner in a parent Child relationship; or

2. Is adopted by or placed for adoption with, or is party in a suit for adoption by, you or your Partner; or

3. Is required to be provided coverage by you or your Partner under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).

Certificate means the document issued for delivery to the Member that lists the benefits, conditions and limits of the Policy.

Collection means Davis Vision's frame or Contact Lens Collection shown in the Schedule of Benefits.

Copayment means the amount a Member is required to pay to the Provider prior to an eye examination or toward the cost of Materials. Copayments, if applicable, are shown in the *Schedule of Benefits*.

Covered Expense means the benefits listed in the *Schedule of Benefits.* The term "Covered Expense" or "Covered Expenses" does not include:

1. Any services or materials that are not listed in the *Schedule of Benefits*; or

2. Any services or materials shown as "Not Available" or "Member is responsible for the entire cost" in the *Schedule of Benefits*; or

3. An additional exam, frame, pair of spectacle lenses or contact lenses for which you have already received either an "In-Network Benefit" or an "Out-of-Network Benefit" during any one Frequency period; or

4. More than one type of contact lens at a time during any one Frequency period; or

5. The fitting and follow-up care or adjustments to eyeglasses (frames and spectacle lenses - including Additional In-Network Items) or contact lenses (including evaluation, fitting and follow-up care) if vision correction is not recommended by a Provider following an eye examination.

Dependent or Dependents means an Employee's:

1. Partner; or

2. Child.

Discount means the percentage that an In-Network Provider has agreed to reduce his charge by for the requested service, material or procedure. Discounts are shown in the *Schedule of Benefits*. Discounted vision services, materials, supplies and treatments described in the *Schedule of Benefits* are not underwritten by us.

Domestic Partner means a person of the same sex who:

1. Is not married or legally separated;

2. Is not currently registered in a domestic partnership with a different Domestic Partner;

3. Occupies the same residence as the Employee;

4. Has not entered into a Domestic Partnership Arrangement that is temporary, social, political, commercial or economic in nature; and

5. Has entered into a Domestic Partnership Arrangement with the Employee.

Domestic Partnership Arrangement means the Employee and another person of the same sex has the following in common (documentation may be requested to the extent allowed by the city, county or state in which you reside):

1. Joint lease, mortgage or deed; and

2. Shared household expenses.

Employee means an Employee of the Policyholder who works at least 20 hours per week and all full time faculty and special lecturers.

Enrollment Period means a period of time agreed upon by the Policyholder and us or our authorized representative during which an Employee may apply for Insurance.

Frequency means the time period shown in the *Schedule of Benefits* during which you are eligible for the Covered Expenses shown in the *Schedule of Benefits*. This time period is measured from the date of your last eye examination or the date you received the eyeglasses, fame or spectacle lenses or contact lenses.

He, him or his means an individual, male or female.

Included means the Covered Service shown in the *Schedule of Benefits* is considered part of the applicable benefit description – you not be paid a separate benefit or charged an additional Copayment for any item listed as "Included".

In-Network Provider means a Provider who has entered into a contract with us or our authorized representative to provide eye examinations and/or materials on a Scheduled Fee basis. These Providers are part of our or our authorized representatives Network.

Insurance means the group vision care Insurance provided to you and your Dependents, if any, under the Policy.

Life Event means one of the following: (1) your marriage or divorce; (2) the death of your spouse or partner; (3) the birth or adoption of your Child; (4) the death of your Child; (5) a change in the employment status of your spouse or partner; or (6) a change in your employment status.

Materials means frames and lenses provided to a Member for ophthalmic correction under the terms and conditions of the Policy.

Member or Members means an eligible Employee or an eligible Dependent for whom an enrollment form has been accepted by us and for whom coverage under the Policy remains in force. The types of Members insured under the Policy are shown under *Members.* For example, if "Employee" is shown we insure all eligible Employees, if "Partner" is shown we insure the Employee's eligible Partner, and if "Children" is shown we insure all eligible Children.

Member's Price means the dollar amount that an In-Network Provider has agreed to accept for the requested service, material or procedure. The Member's Price is shown in the *Schedule of Benefits*.

Network means a group of Providers who have entered into a contract with us or our authorized representative to provide eye examinations and/or materials on a Scheduled Fee basis. Available Networks are shown in the *Schedule of Benefits.*

Other Eligible Adult means a person who:

1. Resides with the Employee and has done so for 18 continuous months and ,
2. Is not related by blood or marriage and,
3. Is not the Employee's landlord, tenant, or boarder; and is not an undocumented immigrant and,
4. Is 26 years of age or older and,
5. Is not a dependent of the Subscriber as defined by the Internal Revenue Service and ,
6. Is not married to any other party and,
7. The Employee and Other Eligible Adult are financially interdependent.
8. The Employee has completed the affidavit of Other Eligible Adult.

Out-of-Network Provider means Providers of optometric services who have *not* entered into a contract with us or our authorized representative to provide vision care services.

Paid in Full means you will not be responsible for any out of pocket expenses for the Covered Service.

Partner means your Spouse or other Eligible Adult.

Professionally Indicated means a service, supply or treatment which is:

1. Ordered by a Provider;

2. Required for treatment or management of a medical condition or symptom;

3. Provided in accordance with approved and generally accepted medical and surgical practice.

Provider means a practitioner who is a legally qualified professional providing eye examinations, refractive and/or post-refractive services and surgery within the scope of their license. This term includes an ophthalmologist, an optometrist, an optician or a surgeon recognized as such in accordance with the laws of the State in which the services are provided**.** The Policy recognizes two categories of Providers; In-Network Providers and Out-of-Network Providers. Refer to these definitions for further information.

This term does not include:

1. A person employed or retained by the Policyholder;

2. A person living in the Member's household; or

3. A parent, sibling, spouse, domestic partner or Child of the Member.

Policyholder means the entity shown on the cover page of this Certificate.

Reimbursement means a flat dollar amount payable under the Policy towards a Covered Expense from an Out-of-Network Provider. Reimbursement levels are shown in the *Schedule of Benefits*. If the Providers charge is less than the Reimbursement we will only pay up to the Providers charge.

Scheduled Fee means the amount negotiated between an In-Network Provider and us or our authorized representative as full payment for a Covered Expense shown in the *Schedule of Benefits* received or purchased by a Member.

Spouse means a person of the opposite sex who is legally married to the Employee.

Usual and Customary Charge means that portion of a charge, as determined by us, made by a Provider for a Covered Expense shown in the *Schedule of Benefits* which does not exceed the lesser of:

1. The customary charge made by other Providers rendering or furnishing such care, treatment or supplies within the same geographic area; or

2. The usual charge the Provider most frequently makes to patients for the same service.

We will base our determination of the customary charges within a geographical area on a study or survey done to determine such charges. Consideration will be given to the nature and severity of the condition being treated including any complications which require additional time, skill, treatment or expertise.

ELIGIBILITY REQUIREMENT MEMBERS

You and are eligible for coverage under the Policy provided:

1. You meet the applicable definition shown in *Definitions*; and

2. You have completed the Waiting Period, if any.

Your Dependents are eligible for coverage under the Policy provided both you and your Dependents meet the applicable definition shown in *Definitions.*

No person is eligible for Insurance under the Policy as both an Employee and Dependent at the same time. If both are eligible as an Employee one but not both may elect Dependent coverage.

EFFECTIVE DATE

Your insurance and your eligible Dependent's insurance is effective on the later of the first day of the month following the date:

1. A completed enrollment form, if any, is submitted for the person or persons to be insured and we approve that form; and

2. The required contribution for the person or persons to be insured has been submitted by your Employer or the required premium for the person or persons to be insured has been paid by you.

A newborn Dependent child is automatically covered from birth provided we receive notification within 31 days after the birth of the newborn.

A child adopted by you or your Partner, or placed for adoption with, or who is a party in a suit for adoption with you or your Partner is covered automatically provided we receive notification:

1. If a newborn within 31 days after the child's birth; or

2. If not a newborn within 31 days after the date of adoption, date of placement for adoption or the date the child becomes a party in a suit for adoption by you or your Partner.

A child required to be provided coverage by you or your Partner under the terms of a Qualified Medical Child Support Order (QMCSO) is covered automatically from the date stipulated in the judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).

APPLYING FOR COVERAGE

You may only apply for coverage on yourself or your Dependents during the following periods:

1. Within 31 days after the date you are or your Dependent is first eligible for coverage; or

2. During an Enrollment Period; or

3. Within 31 days of a Life Event.

You cannot apply for coverage on yourself or your Dependents at any other time. If you do not enroll yourself or your Dependent when *first eligible* you and/or your Dependents will be considered a Late Entrant.

LATE ENTRANTS

A person who meets the *Eligibility Requirement* will be considered a late entrant if the Employee:

1. Does not apply for his insurance or the Dependent's insurance within 31 days of the date he or that Dependent is *first* eligible; or

2. Elects coverage on himself and/or his Dependents within 31 days of the date he or that Dependent is *first* eligible and subsequently voids such coverage within that time period.

An Employee that meets the *Eligiblity Requirement* is *first* eligible of the Effective Date of the Policy or the date he is hired by the Policyholder, if later.

A Partner that meets the *Eligiblity Requirement* is *first* eligible on the Effective Date of the Policy or the date the Employee is hired by the Policyholder, if later; or the date the Employee and Spouse are married, or the date the Employee completes the affidavit of other Eligible Adult,if later.

A Child that meets the *Eligibility Requirement* is *first* eligible on the Effective Date of the Policy, or the date of the child's birth or the date the Employee otherwise acquires the child, if later.

If an Employee does not apply for his insurance or Dependents insurance when he or his Dependent is *first* eligible he must wait until the Policyholder's next Enrollment Period or a Change in Family Status to enroll himself or his Dependents. Coverage for any late entrant who applies for coverage during an Enrollment Period or following a change in Family Status will become effective on the later of the first day of the month following the end of the Enrollment Period or the date he enrolls due to a Change in Family Status provided:

1. A completed enrollment form, if any, is submitted for the person or persons to be insured and we approve that form; and

2. The required contribution for the person or persons to be insured has been submitted by your Employer or the required premium for the person or persons to be insured has been paid.

TERMINATION OF INSURANCE

Please read the *Continuation of Insurance* section of this Policy for information on continuation after eligibility for coverage would otherwise end.

The insurance on a Member will end on the earliest date below:

1. The first day of the month following the date this Policy or insurance for a Covered Class is terminated; or

2. The first day of the month following the date the Member is no longer in a Covered Class or satisfies eligibility requirements under this Policy; or

3. With respect to a Child the last day of the calendar year following the date the Child is no longer in a Covered Class or satisfies eligibility requirements under this Policy; or

4. The last day of the last period for which premium is paid; or

5. The day he reports for active duty in the armed forces of the United States or any other country; or

6. The end of any period of continuation, as provided in the *Continuation of Coverage;* or

7. With respect to a Spouse or other Eligible Adult, the first day of the month following the date of the death of the Employee or the first day of the month following the date of divorce from the Employee, or termination of a other Eligible Adult.

Termination will not affect a claim for benefits incurred while coverage was in effect.

CONTINUATION

1. Family and Medical Leave

   Your coverage and your Dependents coverage may be continued during absences for family or medical leave. If you are on a family or medical leave of absence coverage will continue provided any required premium is paid when due and the Policyholder has approved the leave in writing. Coverage will be continued for up to the greater of the leave period required by the federal Family and Medical Leave Act or the leave period required by applicable state law.

2. Military Leave

   If you or one of your Dependents is called upon to serve in the armed forces of the United States that person's coverage will be continued during such absence until he reports for active duty. Coverage continued during a military leave of absence is subject to notifying your Employer of such leave in writing and continued payment of any required premium when due.

3. Other Layoff or Leave of Absence

   If you are temporarily laid off or given a leave of absence, other than a military leave or a family or medical leave, your coverage and your Dependents coverage may be continued provided any required premium is paid when due and your Employer has approved the leave in writing.

   Temporary layoff or leave of absence means you are temporarily absent from work for the period of time that has been agreed to in advance in writing by your Employer. Normal vacation time is not considered a temporary layoff off or leave of absence.

4. COBRA

   In general, the Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers, (other than certain church employers) who normally employ at least 20 or more employees in the prior calendar year, to temporarily extend their health care coverage to certain categories of employees and their dependents when, due to certain "qualifying events," they are no longer eligible for group coverage. Contact the Policyholder for more information about COBRA and the events that may allow you or your dependents to temporarily extend vision coverage.

REINSTATEMENT

If insurance ends because you become a full time member of the armed forces of the United States you will not have to satisfy any applicable Waiting Period provided you re-enroll yourself and your Dependents and return to Active Service after you leave active military service within the applicable time period specified in the Uniform Services Employment and Reemployment Rights Act (USERRA). If you do not re-enroll yourself and your Dependents within 31 days of the date you return to Active Service from a military leave you must wait until the next Enrollment Period or a Life Event to enroll.

If a Dependent's insurance ends because he becomes a full time member of the armed forces of the United States that person may be re-enrolled if eligible provided he is re-enrolled within the applicable time period specified in the Uniform Services Employment and Reemployment Rights Act (USERRA). If you do not re-enroll this person within 31 days you must wait until the next Enrollment Period or a Life Event to enroll this person.

If insurance ends because you failed to make any required premium payment when due, you must wait until the next Enrollment Period to re-enroll.

EXCLUSIONS

Benefits will not be paid for and the term "Covered Expenses" will not include charges:

1. For any Covered Expense not shown in the Schedule of Benefits.

2. For eye examinations required by an employer as a condition of employment except, as otherwise provided under the Occupational and Safety Program.

3. For services or materials provided in connection with special procedures such as orthoptics and visual training, or in connection with medical or surgical treatment (including laser vision correction) except as provided herein.

4. For lenses which do not provide vision correction, except as provided herein.

5. For charges for the replacement of lost or stolen lenses or frames.

6. For services or supplies furnished to a Member before the effective date of his Insurance under the Policy or after the date a Member's Insurance ends.

7. For services rendered by practitioners who do not meet the definition of Provider.

8. For expenses covered by a health maintenance organization or hospital or medical services prepayment plan available through an employer, union or association.

9. For any expenses covered by any union welfare plan or governmental program or a plan required by law.

10. For Medically necessary contact lenses prescribed for a Member for which prior approval was not obtained by us or our authorized representative.

11. For laser vision correction for which prior approval was not obtained from us or our authorized representative.

CLAIM PROVISIONS

In-Network

A Member must contact an In-Network Provider before receiving services for a Covered Expense. The In-Network Provider will verify his eligibility for Covered Expenses with us or our authorized representative before the examination takes place. The Provider will submit Member's claim directly to us or our authorized representative.

Out-of-Network

When a Member uses an Out-of-Network Provider he must first pay the billed charge and then submit a claim; assignment is not permitted

1. Notice of Claim - written or authorized electronic/telephonic notice of claim must be given to us within 20 days after a Covered Expense is incurred or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized representative. Notice should include the Policyholder's name and the Member's name, address, Policy and Policy Number.

2. Claim Forms - we will send claim forms for filing proof of loss when we receive notice of a claim. If such forms are not provided within 15 days after we receive notice, the proof requirements will be met by submitting, within the time fixed in the Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

3. Proof of Loss - written or authorized electronic proof of loss satisfactory to us must be given to us at our Administrative Office, such other place as we may designate for the purpose, or to our authorized representative within 90 days of the loss for which claim is made.

   If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which we are liable.

   If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to lack of legal capacity.

4. Payment of Claims - we will pay benefits due under the Policy for any loss immediately upon receipt of due written or authorized electronic proof of such loss.

   All benefits will be paid in United States currency. All benefits payable under the Policy, unless otherwise stated, will be payable to the Member or to his estate.

   If we are to pay benefits to the Member's estate or to a person who is incapable of giving a valid release, we may pay up to $1,000 to a relative by blood or marriage that we believe is equitably entitled. Any payment made by us in good faith pursuant to this provision will fully discharge us to the extent of such payment and release us from all liability.

Grievance Review/Appeal Procedures

A Member may request a review of any decision, policy or action on our part that affects their benefits under the Policy. He or she may request either an internal formal review or an internal grievance committee review. If a Member requests an internal formal review and does not agree with our decision, he or she may request an internal grievance committee review. If both the internal formal review and the internal grievance committee review are performed, both review procedures must be completed within 35 total calendar days. If, following that review, the Member does not agree with the findings of the internal grievance committee review, he or she may request an external grievance review by the Michigan Office of Financial and Insurance Regulation.

Note: Any appeal of a “Non-certification” will be treated as an internal grievance committee review. Any request for a review involving a “Medical Emergency” and/or “Emergency Services” will be treated as an expedited internal grievance review.

1. Internal Formal Review

To request an internal formal review a Member should send a written request to us after they receive notice of our decision. No special form is required. As a part of that request for review, the Member may submit issues and comments in writing and provide additional documentation to support his or her claim. The Member has the right to appear before the board of directors or a designated committee or the right to a managerial-level conference to present his or her grievance.

The Member will receive written notice of our decision within 35 days after their request is received. However, that timeframe may only be suspended for periods of time that the Member is permitted to take to file a grievance and for a period of no more than 10 days if we have not received information we have requested from a health care facility or provider.

Our notice will include the reasons for our decision and reference to the provisions of the Policy on which the decision is based. The Member may authorize another person to act on his or her behalf. If the Member agrees with our response, it becomes our final determination and the grievance ends. However, if he or she disagrees with our response to the grievance, the Member may then file a written request for an internal grievance committee review. Written notification of the grievance procedures will be provided to the Member in the event he or she contests the decision of the internal formal review.

Written response to the Member will include notification of the right to submit the results of our review to the Michigan Office of Financial and Insurance Regulation for advisement. A copy of the External Review Request Form FIS 0018 will also be provided, however a request for an external review will not be made until the Member has exhausted our internal grievance process provided for by the law. At any level of the review process, the Member may write or call the Michigan Office of Financial and Insurance Regulation from 8:00 a.m. – Noon and 1:00 p.m. – 5:00 p.m., for assistance. The address and phone number is:

Michigan Office of Financial and Insurance Regulation
Health Plans Division
P.O. Box 30220
611 W. Ottawa, 3rd Floor
Lansing, Michigan 48909
Phone: (517) 373-0220
Toll Free: 1-877-999-6442

2. Internal Grievance Committee Review

To obtain an internal grievance committee review, the Member should send us a written request for review. The Member's health care provider may submit this request on his or her behalf. After receiving the Member's request for review, we will provide that person with the name, address, and telephone number of the coordinator and information on how to submit written material. Neither the Member nor their health care provider may attend an internal grievance committee review.

We will issue a written decision to the Member, or his or her health care provider after the Member's request for an internal grievance committee review is received. The person or persons reviewing this request will not be the same person or persons who initially handled the Member's claim. If the nature or severity of the claim warrants, at least one person reviewing the claim will be a medical doctor with the appropriate expertise to evaluate the claim. The written decision issued in an internal grievance committee review will contain:

a. The professional qualifications and licensure of the person or persons reviewing the grievance.

b. A statement of the reviewers' understanding of the nature of the grievance and all pertinent facts.

c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the Member to respond further to our position.

d. A reference to the evidence or documentation used as the basis for the decision.

e. In the case of a review of a “Non-certification” or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the committee to make the decision.

f. A statement of the Member’s rights, which include the right: (1) to request and receive all information relevant to the case from us; (2) to submit supporting materials before the committee meeting; and (3) ask questions of any member of the committee.

g. A statement that the decision is our final determination in the matter.

Notice of the availability of the Michigan Office of Financial and Insurance Regulation for assistance

You may contact the Michigan Office of Financial and Insurance Regulation from 8:00 a.m. – Noon and 1:00 p.m. – 5:00 p.m. by telephone at (517) 373-0220 or toll free at 1-877-999-6442. The address is:

Michigan Office of Financial and Insurance Regulation
Health Plans Division
P.O. Box 30220
611 W. Ottawa, 3rd Floor
Lansing, Michigan 48909

3. Expedited Internal Grievance Review Procedures

If the Member has an “Emergency Medical Condition” and/or requires “Emergency Services” he or she, or their physician or person acting on behalf of the Member, may request an expedited internal grievance review. If either of these conditions applies, the Member does not have to request an internal grievance committee review before he or she requests an expedited internal grievance review. All of the internal grievance committee review procedures outlined above apply except:

a. We will conduct the review and render our final decision no later than seventy-two hours after receipt of an expedited grievance. Within ten business days after the final determination by us, the insured person or someone authorized to act on behalf of the insured, may request a determination of the matter by the Commissioner. If the final determination by us is made orally, we will provide a written confirmation of the determination to the insured or their representative no later than two business days after the oral determination.

b. The review may take place by way of a telephone conference call, or through the exchange of written information, instead of a review meeting.

As used above:

"**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

"**Emergency Services**" means health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including pre-hospital care and ancillary services routinely available to the emergency department.

"**Non-certification**" means a determination by us (or our designated representative, if any) that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, or terminated. A "Non-certification" is not a decision rendered solely on the basis that the Policy does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the Certificate.

Note: We ensure full investigation into any complaints filed. We agree to provide timely notification in plain English to the Member as to the progress of any investigations. We agree to provide summary data on the number and types of complaints and grievances filed on an annual basis to the Michigan Office of Financial and Insurance Regulation as required. In addition, our management is provided with a Policy Complaint Summary at regular intervals, no less than monthly, to ensure that appropriate actions have been taken in each case. These complaints and grievances are also summarized annually for management review.

For any questions or concerns regarding grievance review or appeal procedures, you may contact either the Administrator (Davis Vision) or us:

Davis Vision
Customer Service
159 Express Street
Plainview, NY 11803
Toll-free: 1-800-328-4728

HM Life Insurance Company
Customer Service
P.O. Box 535061
Pittsburgh, PA 15253
Toll-free: 1-800-328-5433

Claimant Cooperation

Failure of a claimant to cooperate with us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Administration

The Policyholder has given us the authority to review claims for the benefits provided by the Policy and for deciding appeals of denied claims. In this role we will have the authority, in our discretion, to interpret the terms of the Policy, to decide questions of eligibility for coverage or benefits under the plan, and to make any related findings of fact. All decisions made by us in this capacity will be final and binding on participants and beneficiaries of the plan to the full extent permitted by state and federal law.

You are not forbidden from filing a lawsuit against us, within the statute of limitations, to have any dispute settled by a court of proper jurisdiction if you believe that we have not appropriately responded to your requests concerning such proceedings or have acted inappropriately in the handling of your claim.

We will have no responsibility with respect to the administration of the benefit provided by the Policy except as described above. It is understood that our sole liability to the Policyholder and Members under the Policy will be for the payment of benefits provided under the Policy.

We may contract with another entity to perform this function on our behalf.

Legal Actions

No action at law or in equity may be brought to recover under the Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by the Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment

If benefits are overpaid, we have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.

2. A reduction of any amounts payable under the Policy.

If there is an overpayment due when the Member dies, we may recover the overpayment from the Member's estate.

ADMINISTRATIVE PROVISIONS

If a premium is not paid when due, we will cancel the Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the *Schedule of Benefits.* The Policyholder has the sole responsibility to notify Member's of such termination.

Contributions

You may be required to contribute toward all or part of your and your Dependent's Insurance under the Policy. If so you must agree to:

1. Have all or a portion of the cost of both your Insurance and your Dependent's Insurance deducted from your pay; or

2. Remit all or a portion of the cost of both your Insurance and your Dependent's Insurance directly to the Policyholder; or

3. Remit the entire cost of both your Insurance and your Dependent's Insurance directly to us or our authorized representative. A Member may elect to pay any premium billed directly monthly, quarterly, semi-annually or annually.

Direct Billing

If you are being billed directly you will receive a request for payment from us or our authorized representative on or before the premium due date. The premium due date will be shown on the request for payment. You should pay the amount due on or before the premium due date. Payment of the entire premium as it becomes due will maintain the Member's Insurance in force through the date immediately before the next premium due date.

There is a 31 day grace period for remittance of premium billed directly. If you do not pay the premium on or before the premium due date, you may pay the premium during this 31 day period. A Member's Insurance under the Group Policy will remain in force during the grace period. If premium is not remitted before the end of the grace period, the Member's Insurance will terminate automatically at 12:01 A.M. on the last day for which premium was paid.

Termination of a Member's Insurance for nonpayment of premiums billed directly will not influence a Member's right to a claim for benefits which arose prior to the termination. Our liability under the Policy is limited to benefits payable for eligible claims incurred prior to the date of termination.

Reimbursement Requirement

If you stop making the required contribution toward the cost of your Insurance or your Dependent's Insurance, you may be asked to reimburse us for the difference between A minus B, whichever is less where:

A = The amount of the contribution otherwise due for 12 months or until the end of the next Enrollment Period, if earlier.

B = The amount you have contributed from the effective date of coverage or from the beginning of the current Enrollment period, if later.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Policy may be assigned under certain circumstances. Any Member that wants to make an assignment of his Insurance should see the Policyholder for the conditions and further information. We assume no responsibility for the validity, sufficiency, or effect of any assignment of a Member's Insurance (including an assignment on a form furnished by us or by the Policyholder).

Incontestability

All statements made by a Member are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim unless a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of a claimant's death or incapacity, his applicable representative will be given a copy.

After two years from a Member's effective date of Insurance, or from the effective date of increased benefits, no such statement will cause Insurance or the increased benefits to be contested except for fraud.

Clerical Error

A Member's Insurance will not be affected by error or delay in keeping records of Insurance under the Policy. If such error or delay is found, we will adjust the premium fairly.

Conformity with Statutes

Any provisions in conflict with the requirements of any state or federal law that applies to the Policy are automatically changed to satisfy the minimum requirements of such laws.

Compensation Insurance

The Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation, Occupational Disease or similar law.