
# SUMMARY PLAN DESCRIPTION

**for the**

**SOUTHEASTERN FREIGHT LINES**
**VISION COMPONENT PLAN**

**January 1, 2023**

**THIS SUMMARY PLAN DESCRIPTION IS NOT A CONTRACT, EITHER EXPRESS OR IMPLIED.**

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## I. Introduction

This Summary Plan Description ("SPD") is designed to describe the vision coverage provisions (the "Group Vision Coverage") of the Southeastern Freight Lines, Inc. Health Insurance Plan (the "Plan of Benefits") in effect on January 1, 2023, pursuant to which a vision coverage option is offered through your employment as a full-time associate of Southeastern Freight Lines, Inc. (the "Employer"). The Plan of Benefits is a component plan benefit under the Southeastern Freight Lines, Inc. Insurance Plan (the "Insurance Plan"). The terms of this SPD are incorporated into and should be read in conjunction with the Insurance Plan, which contains many of the governing provisions. This SPD is intended to summarize the Insurance Plan rules applicable only to Group Vision Coverage.

This SPD supersedes and replaces all prior SPDs for vision coverage under the Plan of Benefits. The Group Vision Coverage provided under the Plan of Benefits is referred to in this SPD as such or as the Employer's Group Health Plan. In the event there is a conflict between this SPD and the Plan of Benefits, the Plan of Benefits will control. The Group Vision Coverage benefits described in this SPD are insured by EyeMed, which is responsible for their payment. You may find more information concerning your benefits under the Plan of Benefits, including a listing of Participating Providers, by visiting EyeMedVisionCare.com or calling 1-855-264-9912. The Group Vision Coverage uses EyeMed's Access Network. It is in no way a contract or promise of continued employment with the company.

## II. Explanation and Definitions of Terms

Throughout this SPD certain terms starting with capital letters are used to explain the benefits under this Plan of Benefits. Unless the context dictates otherwise, use of the male pronoun in this booklet will be deemed to include the female. To help you better understand the benefits most of these terms are defined within the text or in this Definitions section.

**Associate:** A person who is employed by the Employer.

**Benefit Year:** The Benefit Year for the Group Vision Coverage is January 1 through December 31.

**Employer:** Southeastern Freight Lines, Inc.

**ERISA:** The Employee Retirement Income Security Act of 1974, as amended.

**Group Health Plan:** An employee welfare benefit plan to the extent that such plan provides health benefits to employees or their dependents, as defined under the terms of such group health plan, directly or through insurance, reimbursement, or otherwise. The Plan of Benefits is a Group Health Plan.

**HIPAA:** The Health Insurance Portability and Accountability Act of 1996, and any amendments and regulations thereto.

**Member:** An Associate or Eligible Dependent, as defined in the Insurance Plan, who has enrolled for Group Vision Coverage under this Plan of Benefits. These are also known as "Covered Members."

**Participating Provider:** A provider who has a current, valid agreement with EyeMed to participate in EyeMed's Access network.

**PHI:** Protected Health Information as that term is defined under HIPAA.

**Plan Administrator:** The Employer, who is charged with the administration of the Plan of Benefits.

**Plan of Benefits:** The Southeastern Freight Lines, Inc. Health Insurance Plan.

**Plan Year:** The term "Plan Year" means each twelve-month period, which begins on January 1 and ends on December 31.

**PLUS Provider:** A PLUS Provider is an eye doctor within the EyeMed network who offers an enhanced benefit. Members can visit EyeMed's Provider Locator and look for the PLUS Provider icon to look for PLUS Providers.

**Premium:** The amount paid to the Employer by the Member for Group Vision Coverage under this Plan of Benefits. Payment of Premiums by the Member constitutes acceptance by the Member of the terms of the Plan of Benefits and this SPD.

**You and Your:** The terms "you" and "your" mean the Associate.

## III. Premiums

The Premium schedule will be established annually by the Employer and communicated to you as part of the annual Open Enrollment materials. Failure to pay any Premium when due may result in termination of your elected Group Vision Coverage.

## IV. Disclosure of Medical Information

By accepting Benefits or payment of Covered Expenses, the Member agrees that the Employer's Group Health Plan (including BlueCross on behalf of the Employer's Group Health Plan) may obtain claims information, medical records, and other information necessary for the Employer's Group Health Plan to consider a request for Preauthorization, a Continued Stay Review, an Emergency Admission Review, a Preadmission Review or to process a claim for Benefits.

## V. Schedule of Benefits

| Vision Care Services | Participating Providers | Out-of-Network Reimbursement |
|---|---|---|
| **Exam with Dilation as Necessary** | $10 Copayment | $35 |
| **Exam with Dilation as Necessary at a PLUS Provider** | $0 Copayment | N/A |
| | | |
| **Retinal Imaging Benefit** | Up to $39 | N/A |
| | | |
| **Contact Lens Fit and Follow-Up**<br>(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed)**:** | | |
| Standard Contact Lens Fit and Follow-up | $0 Copayment, Paid-in-full fit and two follow-up visits | $40 |
| | | |
| Premium Contact Lens Fit and Follow-up | $0 Copayment, 10% off retail price, then apply $55 allowance | $40 |
| | | |
| **Frames** | | |
| Any available frame at provider location | $0 Copayment, $130 allowance, 20% off balance over $130 | $65 |
| Any available frame at PLUS Provider location | $0 Copay; $180 allowance, 20% off balance over $180 | $65 |

| Vision Care Services | Participating Providers | Out-of-Network Reimbursement |
|---|---|---|
| | | |
| **Standard Plastic Lenses:** | | |
| Single Vision | $25 Copayment | $25 |
| Bifocal | $25 Copayment | $40 |
| Trifocal | $25 Copayment | $55 |
| Lenticular | $25 Copayment | $55 |
| Standard Progressive Lens | $25 Copayment | $55 |
| Premium Progressive Lens | $25 Copayment, 80% of Charge less $120 | $55 |
| | | |
| **Lens Options:** | | |
| UV Treatment | $15 | N/A |
| Tint (Solid and Gradient) | $15 | N/A |
| Standard Plastic Scratch Coating | $15 | N/A |
| Standard Polycarbonate - Adults | $40 | N/A |
| Standard Polycarbonate – Kids under 19 | $0 Copayment | $5 |
| Standard Anti-Reflective Coating | $45 | N/A |
| Polarized | 20% off Retail Price | N/A |
| Other Add-Ons | 20% off Retail Price | N/A |
| | | |
| **Contact Lenses** (Contact lens allowance includes materials only)**:** | | |
| Conventional | $0 Copayment, $130 Allowance, 15% off balance over $130 | $104 |
| Disposable | $0 Copayment, $130 Allowance, plus balance over $130 | $104 |
| Medically Necessary | $0 Copayment, Paid-in-Full | $210 |
| | | |
| Lasik or PRK from U.S. Laser Network | 15% off Retail Price or 5% off promotional price | N/A |
| | | |
| **Additional Pairs Benefit:** | Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used | N/A |
| | | |
| **Frequency:** | | |
| Examination | Once every calendar year | |
| Lenses or Contact Lenses | Once every calendar year | |
| Frame | Once every two calendar years | |

## VI. Claims Filing Procedures

Where a Participating Provider provides services, the Participating Provider will file the claim on a Member's behalf with EyeMed, provided the Member shows his Identification Card at the time he receives services.

For Benefits not provided by a Participating Provider, the Member is responsible for filing claims with EyeMed. When filing the claims, the Member will need the following:

**i.** A claim form for each Member. Members can get claim forms from a member services representative at 1-888-939-3633 or via EyeMed's website, www.eyemed.com.

**ii.** Itemized bills from the provider (s). These bills should contain all the following:

1. Provider's name and address;
2. Member's name and date of birth;
3. Description and cost of each service; and
4. Date that each service took place.

Members must complete each claim form and attach the itemized bill(s) to it. Members should make copies of all claim forms and itemized bills for the Member's records since they will not be returned. Claims should be mailed to EyeMed's address listed on the claim form.

EyeMed must receive the claim within one (1) year after the beginning of services. EyeMed is not obligated to pay claims submitted after this period.

## VII. Appeal Procedures

Members will be provided notice of the benefit determination made by EyeMed on their claim. If a Member is not satisfied with the decision, he is entitled to an appeal of the benefit determination.

To obtain a review, a Member or his authorized representative should submit his request in writing to:

EyeMed Vision Care
Attn: Quality Assurance
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

Members may request a review within 180 days of the date of the benefit determination. With the request, a Member may also submit written comments, documents, records, and other information that he wishes to have considered as part of the review.

If an internal rule, guideline, or protocol was relied upon in making the benefit determination, it will be provided free of charge upon request by the Member or his authorized representative. The documents relevant to your claim will be provided free of charge upon request by the Member or the Member's authorized representative.

Members will be notified of the final decision upon review in a timely fashion, but no later than 60 calendar days if your plan is governed by ERISA. If a Member does not agree with the final decision on review the Member may have the right to bring legal action under section 502(a) of ERISA.