



COMBINED INSURANCE

Combined Insurance Company of America

111 Wacker Drive, Suite 700 • Chicago, Illinois 60601
Administrator's Office: 4000 Luxottica Place; Mason, OH 45040

GROUP VISION INSURANCE POLICY

POLICY NUMBER: 1018944
POLICYHOLDER: Johns Hopkins University
STATE OF ISSUE: Maryland
POLICY EFFECTIVE DATE: January 1, 2019
POLICY ANNIVERSARY DATE: January 1, 2020, and each January 1 thereafter

Combined Insurance Company of America agrees to pay the benefits provided by the Policy in accordance with its terms and conditions.

The Policy is issued in consideration of the Policyholder's application (a copy of which is attached) and receipt by the Company of the premiums.

All periods of time under the Policy begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy may be modified by mutual agreement between the Policyholder and the Company.

The Policy is issued by Combined Insurance Company of America at Chicago, Illinois on the Policy Effective Date.

Signed for **Combined Insurance Company of America**

Brad Bennett, President

Rebecca L. Collins, Secretary

THIS IS A LIMITED BENEFIT POLICY

Please read the Policy carefully.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. IT IS NOT DESIGNED TO FILL THE "GAPS" OF MEDICARE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE MEDICARE SUPPLEMENT BUYER'S GUIDE AVAILABLE FROM THE COMPANY.

PREMIUMS

Premiums are payable in advance by the Policyholder. The first premium is due on the effective date of the Policy. Subsequent premiums are due on the first day of each month thereafter.

The required premium due on each premium due date is the sum of the premiums for all Insureds and their Dependents covered under the Policy. The premiums due will be determined by applying the premium rates then in effect for each plan provided by the Policy to the number of Insured Persons. All premiums are payable to the Company at the Company's home office or to any of the Company's authorized agents.

The premium due may be adjusted due to a change in insurance as requested by the Policyholder or as required by the Company as follows:

1. if an amount of insurance is added or increased during a calendar month, premiums will be increased as of the date the change becomes effective;
2. if an amount of insurance is deleted or decreased during a calendar month, premium will cease or be decreased at the end of the calendar month in which the deletion or decrease occurred;
3. if the Policyholder's contribution percentage is changed, premium will be adjusted at the end of the calendar month in which the change occurred; or
4. if the number of eligible employees increases or decreases by more than 10%, premium will be adjusted at the end of the calendar month in which the increase or decrease occurred.

If premiums are due the Company, or premium refunds are due the Policyholder as a result of clerical error or delay in the reporting of dates and/or data to the Company, all premiums or refunds will be calculated at the current rate of premium payment and are limited to a maximum period of the current month plus three months.

Premium Rate Change. The Company has the right to change the premium rate on or after the fourth Policy Anniversary Date. The Company will provide written notice at least 45 days before the date of change.

Grace Period. A grace period of 30 days will be allowed to the Policyholder for the payment of each premium due after the first premium. The Policy will remain in force during the grace period. If the required premium is not paid by the end of the 30-day period, the Policy will terminate. The Policyholder will be required to pay premium for the grace period.

Return of Premium. For the first two years from the date of issue of this Policy, the Company reserves the right to rescind the coverage for one or all Insureds due to misrepresentation or fraud on the Policyholder's application or an Insured's enrollment form, if such misrepresentation materially affected the acceptance of the risk.

If, on the date coverage is rescinded, no claims have been paid under the Policy, the Company will return all premiums paid for such coverage to the Policyholder.

After this Policy has been in force for two years from its date of issue, the Policy may not be contested except for non-payment of premium.

If, on the date coverage is rescinded, claims have been paid under the Policy, the Company reserves the right to deduct an amount equal to the amount of such claims paid from the premiums to be returned to the Policyholder.

TERMINATION OF POLICY

The Policyholder or the Company may terminate or cancel the Policy on the earliest of the following:

1. on any date on or after the fourth Policy Anniversary Date. The Policyholder may terminate this Policy at any time without giving notice. The Company will give written notice to the Policyholder at least 45 days prior to termination;
2. the date the number or percentage of persons covered under the Policy does not meet the minimum participation requirement of 10;
3. the date the required premium has not been paid, except as provided in the Grace Period provision; or
4. the date 100% of the eligible employees are not covered when a contribution is not required by the employee.

The Policyholder is responsible for notifying the Insured of the termination of the Policy.

CERTIFICATES

The Company will furnish a Certificate for each Insured to the Policyholder which will set forth the essential features of the insurance coverage.

ADDITIONAL INSUREDS

Insured Persons may be added at any time if they meet the eligibility requirements stated in the Policyholder's application, complete an enrollment form, if required, and pay any required premium.

INCORPORATION PROVISION

The provisions of the attached Certificate and all Rider(s) issued to amend the Policy after the Policy Effective Date are made a part of the Policy.



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GROUP VISION INSURANCE CERTIFICATE

POLICY NUMBER: 1018944
POLICYHOLDER: Johns Hopkins University
POLICY ANNIVERSARY DATE: January 1, 2020, and each January 1 thereafter

Combined Insurance Company of America represents that the Insured Person is insured for the benefits described on the following pages, subject to and in accordance with the terms and conditions of the Policy.

The Policy may be amended, changed, cancelled or discontinued without the consent of any Insured Person.

The Certificate explains the plan of insurance. An individual identification card will be issued to the Insured containing the group name, group number and Insured's effective date. The Certificate replaces all certificates previously issued to the Insured under the Policy.

All periods of time under the Policy will begin and end at 12:01 A.M. Local Time at the Policyholder's business address.

The Policy is issued by Combined Insurance Company of America at Chicago, Illinois on the Policy Effective Date.

Signed for **Combined Insurance Company of America**

Brad Bennett, President

Rebecca L. Collins, Secretary

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DEFINITIONS

Please note certain words used in this document have specific meanings. These terms will be capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Allowance means, as specified in a schedule of benefits, the maximum dollar amount the plan will pay toward the cost of a vision service or material. If the Insured Person receives vision services from an In-Network, the Insured Person is responsible for any cost above the Allowance shown in the Schedule of Benefits. If the Insured Person receives vision services from an Out-of-Network Provider, the Insured Person's Allowance will generally be less than the Allowance for the same vision services from an In-Network Provider, and the Insured Person is responsible for any cost above the Out-of-Network Allowance shown in the Schedule of Benefits.

Benefit Frequency means the period of time in which a benefit is payable.

The Benefit Frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new Benefit Frequency begins at the expiration of the previous Benefit Frequency.

Co-payment means the designated amount, if any, shown in the Schedule of Benefits each Insured Person is responsible for a covered Vision Examination and Vision Materials per Benefit Frequency.

Comprehensive Eye Examination means a comprehensive ophthalmological service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under "Eyes-examination items". Comprehensive ophthalmological service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated by examination, biomicroscopy, examination with cyclopegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Dependent means any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse or Domestic Partner;
2. each unmarried child or grandchild from birth to age 19 who is primarily dependent upon the Insured for support; or
3. each unmarried child or grandchild at least 19 years of age to 25 years of age who is primarily dependent upon the Insured for support and who is a full-time student; or
4. each unmarried child at least 19 years of age who is primarily dependent upon the Insured for support because the child is incapable of self support by reason of mental incapacity or physical incapacity that started before the child, grandchild, or individual under guardianship attained the limiting age; and who was so incapacitated and is an Insured Person under the Policy on his or her 19th birthday; and who has been continuously so incapacitated since his or her 19th birthday.
5. each unmarried child at least 19 years old who a student and who is enrolled less than full time as a result of a documented disability that prevents the student from maintaining a full-time course load; and who is maintaining a course load of at least seven (7) credit hours per semester. The Company may request verification of the disability from a disability services professional employed by the institution of higher education that the student attends or a health care provider with special expertise in and knowledge of the disability.

Child includes stepchild, foster child, grandchild, legally adopted child, child legally placed in the Insured's home for adoption and child under the Insured's legal guardianship. A full-time student is one who is enrolled at least the minimum number of hours of class a week the school considers as full-time status.

Domestic Partner means an adult who is in a committed relationship with the Insured, and the Insured and the Domestic Partner are mutually responsible for one another financially and otherwise. To qualify as a Domestic Partner or Dependent under the Policy, all of the following conditions must be met:

1. the Domestic Partner and the Insured are over the age of 18 and are mentally competent to enter into contracts;
2. the Domestic Partner and the Insured reside in the same household;
3. the Domestic Partner and the Insured have a committed relationship with each other for no less than six months; intend to continue the relationship indefinitely and have no such relationship with any other person;
4. the Domestic Partner and the Insured are not related by blood;

5. the Domestic Partner and the Insured are not married to any third party;
6. the Domestic Partner and the Insured are of the same sex or opposite sex; and
7. the Domestic Partner and the Insured are not claiming Dependent status for the primary purpose of gaining insurance coverage under the Policy.

The term “spouse”, wherever used, will include a Domestic Partner.

Insured means an employee of the Policyholder who meets the eligibility requirements as shown in the Policyholder’s application, and whose coverage under the Policy is in force and has not ended.

Insured Person means the Insured. Insured Person will also include the Insured’s Dependents, if enrolled.

IntraLase Initiated LASIK means a LASIK surgical procedure in which a special laser is used instead of a blade to create the stromal flap.

In-Network Provider means a Provider who has signed a Preferred Provider Agreement with the PPO.

LASEK (Laser Assisted Epithelium Keratomileusis) means a surgical procedure that utilizes a trephine to create an epithelial flap and an alcohol solution to preserve the epithelial cells. Once the epithelial flap is created and lifted, the treatment proceeds as for traditional PRK, with light smoothing at its conclusion. The epithelial flap is then repositioned with a small spatula.

Laser Vision Correction Procedures means surgical procedures which permanently alter the focusing power of the eye(s) in order to change refractive errors.

LASIK (Laser Assisted In-Situ Keratomileusis) means a surgical procedure involving the use of a computer-controlled excimer laser to reshape the cornea (epithelium) without invading the adjacent cell layers. An automated microkeratome is used to create a stromal flap of the cornea that is lifted, and the exposed surface is reshaped using the laser. After altering the cornea curvature, the stromal flap is replaced and is adhered without stitches.

Out-of-Network Provider means a Provider, located within the PPO Service Area, who has not signed a Preferred Provider Agreement with the PPO.

Policy means the Policy issued to the Policyholder.

Policyholder means the Employer named as the Policyholder in the face page of the Policy.

PPO Service Area means the geographical area where the PPO is located.

Preferred Provider Agreement means an agreement between the PPO and a Provider that contains the rates and compensation methods for services and supplies provided by such Provider.

Preferred Provider Organization (“PPO”) means a network of Providers and retail chain stores within the PPO Service Area that has signed a Preferred Provider Agreement.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician.

Vision Examination means any eye or visual examination covered under the Policy and shown in the Schedule of Benefits.

Vision Materials means those materials shown in the Schedule of Benefits.

Visual Impairment Appropriate Contact Lenses means:

1. Keratoconus where the Insured Person is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;
2. High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
3. Anisometropia of 3D in spherical equivalent or more; or
4. vision for an Insured Person can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle.

EFFECTIVE DATES

Effective Date of Insured's Insurance. The Insured's insurance will be effective as follows:

1. if the Policyholder does not require the Insured to contribute towards the premium for this coverage, the Insured's insurance will be effective on the date the Insured became eligible;
2. if the Policyholder requires the Insured to contribute toward the premium for this coverage, the Insured's insurance will be effective on the date the Insured became eligible, provided:
 - a. the Insured has given the Company the Insured's enrollment form (if required) on, prior to, or within 30 days of the date the Insured became eligible; and
 - b. the Insured has agreed to pay the required premium contributions; and
3. if the Insured fails to meet the requirements of 2 a) and 2 b) within 30 days after becoming eligible, the Insured's coverage will not become effective until the Company has verified that the Insured has met these requirements. The Insured will then be advised of the Insured's effective date.

Effective Date of Dependents' Insurance. Coverage for Dependents becomes effective on the later of:

1. the date Dependent coverage is first included in the Insured's coverage; or
2. the premium due date on or after the date the person first qualifies as the Insured's Dependent. If an enrollment form is required, the Insured must provide such form and agree to pay any premium contribution that may be required prior to coverage becoming effective.

If the Insured and the Insured's spouse are both Insureds, one Insured may request to be a Dependent spouse of the other. A Dependent child may not be covered by more than one Insured.

Newborn Children. A Dependent child born while the Insured's coverage is in force will be covered from the moment of birth for 31 days or greater, if elected. If premium payment is required, in order to continue coverage beyond this period, the Insured must provide notice to the Company within the first 31 days of the date of birth and agree to pay any premium contribution that may be required within this period.

Adopted Children. If a Dependent child is placed with the Insured for adoption while the Insured's coverage is in force, this child will be covered from the date of adoption for 31 days or greater, if elected. "Date of adoption" means the earlier of: 1) a judicial decree of adoption; or 2) the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent. If premium payment is required, in order to continue coverage beyond this period, the Insured must provide notice to the Company within the first 31 days from the date of adoption and agree to pay any premium contribution that may be required within this period. If proper notice has been given, coverage will continue unless the adoption is disrupted prior to legal adoption and the child is removed from the Insured's custody.

Grandchildren – The Insured's grandchild will be covered from the moment of birth if, the child is the Insured's Dependent and in the Insured's Court Ordered custody. If any additional premium is required, a notice of birth together with additional premium, if any, must be submitted to the Company. This must be done within 31 days after the date of birth to continue coverage beyond the 31-day period.

Minor Children Coverage – A minor child for whom guardianship has been granted by court or testamentary appointment is covered from the date of appointment. Such coverage will continue until appointment is terminated. If any premium is required, notification with the premium must be submitted to the Company. This must be done within 31 days after the date of such appointment to continue coverage beyond the 31-day period.

Insuring Parent - If Insured is an Insuring Parent, the Company will not deny the enrollment, at any time, for a child, because the child:

1. was born out of wedlock;
2. is not a dependent claimed on the Insured's federal income tax;
3. does not live:
 - a. with the Insured; or
 - b. in the Company's service area.
4. is receiving benefits or is eligible to receive benefits under the Maryland Medical Assistance Program.

Insuring Parent means a parent who is required under a court or administrative order to provide health insurance coverage for a child; or otherwise provides health insurance coverage for a child. Noninsuring Parent means a parent other than the Insuring Parent.

A Court Order is a ruling that is issued by a court within the State of Maryland or another state or an administrative agency of another state; and creates or recognizes the right of a child to receive benefits under a parent's health insurance coverage.

The Company will allow the Insuring Parent to enroll for family coverage and include the child in that coverage regardless of enrollment period restrictions. Should the Insuring Parent not enroll the child the Company will allow the Noninsuring Parent, the Child Support Enforcement Agency, or the Department of Health and Mental Hygiene to enroll the child regardless of enrollment period restrictions. The Company will not cancel the coverage unless receive written evidence that:

1. the order is no longer in effect;
2. the child has been or will be covered by other reasonable health insurance coverage which takes effect on or before the date this coverage ends;
3. the employer ceases to offer family coverage to all employees; or
4. the Insuring Parent is no longer employed by the employer (should the Insuring Parent elect his rights under COBRA, the child must be included).

The Company will provide the Noninsuring Parent a membership card (if applicable), claim forms and any other information needed to obtain benefits for the child. The Company will process claims and make the appropriate payment to the Noninsuring Parent, provider of care, or the Department of Health and Mental Hygiene when the Noninsuring Parent incurs an expense covered by the Policy.

Within 20 business days after receipt of a medical support notice from an employer, the Company will determine whether the medical support notice contains the employee's name and mailing address and the child's name and mailing address or the address of a substituted official. If the medical support does not contain the required information, the Company will forward the appropriate part of the medical support notice to the child support enforcement agency informing that the notice does not constitute as a qualified medical support order.

If the insurance requires that the Insuring Parent be enrolled in order for coverage to be provided to the child and the parent is not enrolled the Company will enroll both the parent and the child, without regard to enrollment period restrictions. If the child is eligible for enrollment, the Company will cover that child without regard to enrollment period restrictions. The Company will complete the enrollment within 20 days of notice from the employer.

Coverage of Child(ren) after Death of Spouse – An Insured may add his or her Dependent child(ren) for coverage under this Policy, without evidence of insurability, if: 1) the Dependent child(ren) previously were covered under the policy or contract of the Insured's spouse; and 2) the Insured's spouse has died, regardless of whether the Dependent child(ren) are eligible for any continuation or conversion privileges under the spouse's policy or contract. The Insured must exercise this provision within six (6) months after the death of the Insured's spouse.

Coverage of Dependents after Loss of Coverage– An Insured may add his or her spouse and/or Dependents for coverage under this Policy, without evidence of insurability, at any time if the Insured's spouse loses coverage under another group vision contract or policy because of the involuntary termination of the spouse's employment other than for cause. The Insured must notify the Policyholder within six (6) months after the date on which the spouse's coverage under the other group vision contract or policy terminates in order to exercise this provision.

BENEFITS

Benefits are payable for each Insured Person as shown in the Schedule of Benefits for expenses incurred while this insurance is in force.

Comprehensive Eye Examination. An Insured Person is eligible for one Comprehensive Eye Examination in each Benefit Frequency.

In-Network Provider Benefits. The maximum benefit for vision services from an In-Network Provider is the Allowance shown in the Schedule of Benefits. The Insured Person is responsible for any Co-payment or any cost above the Allowance shown in the Schedule of Benefits. The In-Network Provider will file a claim with the Company.

Out-of-Network Provider Benefits. The Insured Person must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Company. The Company will pay the Insured Person for the Out-of-Network Provider benefits up to the maximum dollar amount shown in the Schedule of Benefits.

Referrals to Specialists Provision – An Insured Person may request a referral to a specialist or nonphysician specialist who is not part of the Company’s Provider Network if: 1) the Insured Person is diagnosed with a condition or disease that requires specialized vision care services or vision medical care; and a) the Company does not have in its Provider Network a specialist or nonphysician specialist with the professional training and expertise to treat or provide vision care services for the condition or disease; or b) the Company cannot provide reasonable access to a specialist or nonphysician specialist with the professional training and expertise to treat or provide vision care services for the condition or disease without unreasonable delay or travel.

For the purposes of applying any co-payments that are the responsibility of the Insured Person, services received in accordance with this Provision shall be treated as if the service was provided by a provider in the Company’s Provider Network.

Vision Materials. If a Vision Examination results in an Insured Person needing corrective Vision Materials for the Insured Person’s visual health and welfare, those Vision Materials prescribed by the Provider will be supplied, subject to certain limitations and exclusions of the Policy, as follows:

- *Lenses* provided one time in each Benefit Frequency.
- *Frame(s)* provided one time in each Benefit Frequency.
- *Contact Lenses* provided one time in each Benefit Frequency in lieu of lenses.

LIMITATIONS

Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy.

Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from:

1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2. medical and/or surgical treatment of the eye, eyes or supporting structures;
3. any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
4. services provided as a result of any Workers’ Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof. This exclusion does not apply to services rendered to an Insured who is eligible for Medicaid.
5. plano (non-prescription) lenses;
6. non-prescription sunglasses;
7. two pair of glasses in lieu of bifocals;
8. services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials (lenses, frames or contact lenses) ordered before coverage ended are received within 30 days after the date of such order;
9. lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available; and
10. claims, bills, or other demands or requests for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit the Company from providing insurance, including, but not limited to, the payment of claims.

TERMINATION OF INSURANCE

The Policyholder or the Company may terminate or cancel the Policy as shown in the Policy.

For All Insureds. The Insureds' insurance will cease on the earliest of the following dates:

1. the date the Policy ends;
2. the end of the last period for which any required premium contribution agreed to in writing has been made;
3. the date the Insured is no longer eligible for insurance; or
4. the date the Insured's employment with the Policyholder ends. The Policyholder may, at the Policyholder's option, continue insurance for individuals whose employment has ended, if the Policyholder:
 - a. does so without individual selection between Insureds; and
 - b. continues to pay any premium contribution for those individuals.

For Dependents. A Dependent's insurance will cease on the earlier of:

1. on the date the Insured's coverage ends;
2. the date on which the Dependent ceases to be an eligible Dependent as defined in the Policyholder's application; or
3. the end of the last period for which any required premium contribution has been made.

A Dependent child will not cease to be a Dependent solely because of age if the child is:

1. not capable of self-support due to mental or physical incapacity that began before the age limit was reached; and
2. mainly dependent on the Insured for support.

Within 31 days after the Dependent child reaches the age limit, the Insured must send the Company proof of the child's incapacity or dependency.

The Company may require the same proof again, but will not ask for it more than once a year after this coverage has been continued for two years. This continued coverage will end:

1. on the date the Policy ends;
2. on the date the incapacity or dependency ends;
3. on the end of the last period for which any required premium contribution for the Dependent child has been made; or
4. 60 days following the date the Company requests proof and such proof is not provided to the Company.

CLAIMS

Notice of Claim. If the Company requires written notice of claim, it must be given to the Company within 60 days after the occurrence or commencement of any loss covered by the Policy, or as soon as is reasonably possible. A claim will not be invalidated or reduced if it is shown that it was not reasonably possible to give notice within the time frame and that notice was given as soon as was reasonably possible. Notice given by or for the Insured Person to the Company at the Company's home office, to the Company's authorized administrator or to any of the Company's authorized agents with sufficient information to identify the Insured Person will be deemed as notice to the Company.

Claim Forms. The Company will furnish claim forms to the Insured Person within 15 days after notice of claim is received. If the Company does not provide the forms within that time, the Insured Person may send written proof of the occurrence, character and extent of loss for which the claim is made within the time stated in the Policy for filing proof of loss.

Proof of Loss. Written proof of loss must be furnished to the Company at the Company's home office within 90 days after the date of the loss. Failure to furnish proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within that time, if the proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity, will proof of loss be accepted later than one year from the time proof is required.

Time Payment of Claims. Any benefit payable under the Policy will be paid immediately, but not more than 30 days, upon receipt of due written proof of loss.

Payment of Claims - Benefits will be paid directly to the provider if an assignment is made. All other benefits will be payable to the Insured, unless before such payment, the Company receives a written assignment of benefits to a provider.

If the Company is to pay benefits to the Insured's estate or a person who is a minor, or not competent to give a valid release for

payment, a payment not to exceed \$5,000.00 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who in the Company's opinion, is equitably entitled. Any good faith payment the Company makes fully discharges the Company's liability to the extent of the payment made.

Reimbursement For Services Provided By The Department: If The Department of Health and Mental Hygiene notifies the Company that the Department has paid for or provided services to an individual who is covered under this Policy, the Company will reimburse the Department for the cost of the services, regardless of any provision in this Policy that requires us to pay the provider of service or the Insured.

The benefits payable to the Department of Health and Mental Hygiene under this section are limited to those benefits available under the terms and conditions of this Policy for the services paid for or provided by the Department.

The Company is not required to make payment to the Department under this provision if, before receiving the notice from the Department, We have already paid the benefits available under this Policy in good faith and in accordance with the terms and conditions of this Policy.

The Company may not refuse to reimburse the Department of Health and Mental Hygiene because of the manner, form or date of a claim for reimbursement if, within 2 years after the date of the service for which reimbursement is sought, the Department provides to us sufficient information to determine the Company's liability.

Legal Actions. No Insured Person can bring an action at law or in equity to recover on the Policy until more than 60 days after the date written proof of loss has been furnished according to the Policy. No such action may be brought after the expiration of three years after the time written proof of loss is required to be furnished. If the time limit of the Policy is less than allowed by the laws of the state where the Insured Person resides, the limit is extended to meet the minimum time allowed by such law.

Extension of Benefits – When the Insured's coverage ends, the Company will cover any glasses or contact lenses ordered prior to the date coverage ends. The glasses or contacts must be received by the Insured within 30 days after the order date.

GENERAL PROVISIONS

Clerical Error. Clerical errors or delays in keeping records for the Policy will not deny insurance that would otherwise have been granted, nor extend insurance that otherwise would have ceased, and call for a fair adjustment of premium and benefits to correct the error.

Conformity to Maryland Law. Any provision of the Policy that is in conflict with the laws of the state in which it is issued is amended to conform to the laws of that state.

Entire Contract. The Policy, including any endorsements and riders, the Certificate, the Policyholder's application, which is attached to the Policy when issued, the Insured's individual enrollment form, if any, and the eligibility file, if any, are the entire contract between the parties. A copy of the Policy may be examined at the Office of the Policyholder during normal business hours. An amendment to the Policy may not be valid until it is approved by the Company's executive officer and unless the approval is endorsed on the Policy or attached to the Policy.

Amendments and Changes. No agent is authorized to alter or amend the Policy, or to waive any conditions or restrictions herein, or to extend the time for paying any premium. The Policy and the Certificate may be amended at any time by mutual agreement between the Policyholder and the Company without the consent of the Insured, but without prejudice to any loss incurred prior to the effective date of the amendment. No person except an Officer of the Company has authority on behalf of the Company to modify the Policy or to waive or lapse any of the Company's rights or requirements.

Contestability of Coverage. A statement made by any person covered under the policy relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of two years during the person's life time. Absent fraud, each statement made by the applicant, group policyholder or by any Insured is considered to be a representation and not a warranty. A statement made to effectuate insurance may not be used to avoid the insurance or reduce benefits under the policy unless:

1. The statement is contained in a written instrument signed by the group policyholder or insured; and
2. A copy of the statements is given to the group policyholder, insured, or beneficiary of the insured.

The Policy and this Certificate cannot be contested, except for non-payment of premiums, after it has been in force for two years from its date of issue.

Insurance Data. The Policyholder must give the Company the names and ages of all individuals initially insured. The names of persons who later become eligible (whether or not the person becomes insured), and the names of those who cease to be eligible must also be given. The eligibility dates and any other necessary data must be given to the Company so that the premium can be determined.

The Company has the right to audit the Policyholder's books and records as the books and records relate to this insurance. The Company may authorize someone else to perform this audit. Any such inspection may be done at any reasonable time.

Workers' Compensation. The Policy is not a Workers' Compensation policy. The Policy does not satisfy any requirement for coverage by Workers' Compensation Insurance.

APPEALS PROCEDURE

Note: References to "You" mean the Insured, and include the Insured's authorized representative.

References to "Us" or "Our" mean Combined Insurance Company of America, and include the Company's authorized Administrator.

Form and Manner of Request

Complaints and or Appeals may be made by telephone, in person, by mail, or by electronic means at the telephone number, address or website below. An oral Complaint or Appeal made by You will be reduced to writing by Us. A copy will be sent to You within 48 hours of receipt, except where this time limit is waived or extended by mutual written agreement You and Us.

EyeMed Vision Care
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
or
1-513-765-3024

Any Complaint or Appeal that requires the review of medical records will require the signature of the Member on a form provided promptly by Us. This will authorize the release of medical and treatment information relevant to the Complaint or Appeal to Us when necessary, in a manner consistent with state and federal law. You will have access to any medical information and records relevant to the Complaint or Appeal, which is in Our possession and control. We will request the authorization from You when necessary for requests reduced to writing by Us and for any written requests lacking the authorization.

Acknowledgment of Complaints or Appeals

We will send You written acknowledgment of the receipt of a Complaint or an Appeal within 15 business days except where an oral Complaint or Appeal has been reduced to writing by Us pursuant to the above section, or if this time period is waived or extended by mutual written agreement between You and Us. If We do not have sufficient information to complete Our review, We will notify You within five (5) working days after receipt of the Complaint or Appeal explaining that We cannot proceed with reviewing the Complaint or Appeal unless additional information is provided, and We will assist You in gathering the necessary information without further delay.

Time Requirements for Resolution of Coverage Complaints

We will provide You and Your health care provider with a written Decision of a Coverage Complaint within 30 calendar days after the Coverage Decision has been made. The written notice will state in clear, understandable language the specific factual bases for Our Coverage Decision, and will include the following information:

1. that You or a health care provider acting on Your behalf, has a right to file an appeal with Us; and
2. that You or a health care provider acting on Your behalf, may file a complaint with the Commissioner without first filing an Appeal with Us, if Our Coverage Decision involves an urgent medical condition for which care has not been rendered; and
3. the Commissioner's address, telephone number, and facsimile number; and
4. that the Health Advocacy Unit is available to assist You in both mediating and filing an Appeal under Our Appeal process; and
5. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit

When a Coverage Complaint requires the review of medical records, the 30 calendar day period will not begin to run until You submit a signed authorization for release of medical records and treatment information. If the signed authorization is not provided to Us within 30 calendar days, We may issue a resolution of the Coverage Complaint without review of some or all of the medical records.

The time limits may be waived or extended by mutual written agreement between the You and Us.

Time Requirements for Resolution of Appeals

We will provide You and Your health care provider with a written resolution of an Appeal within 30 calendar days after the Appeal Decision has been made. The written notice will state in clear, understandable language the specific factual bases for Our Appeal Decision, and will include the following information:

1. that You or a health care provider acting on Your behalf, has a right to file a complaint with the Commissioner of Insurance within 60 working days after receipt of Our Appeal Decision; and
2. the Commissioner's address, telephone number, and facsimile number.

When an Appeal requires the review of medical records, the 30 calendar day period will not begin to run until You submit a signed authorization for release of medical records and treatment information. If the signed authorization is not provided to Us within 30 calendar days, We may issue a resolution of the Appeal without review of some or all of the medical records.

The time limits may be waived or extended by mutual written agreement between the You and Us.

Review of Appeals / Complaints

An individual or individuals who are knowledgeable about the matters at issue in the Appeal / Complaint will review the Appeal / Complaint.

Form of Written Resolution

The written resolution notice will state in clear, understandable language the specific factual bases for Our decision, and will include the following information:

1. that You or a health care provider acting on Your behalf, have a right to file a complaint with the Commissioner within 60 working days after receipt of Our appeal decision; and
2. the Commissioner's address, telephone number, and facsimile number.

Time Limits

Time limits include any extensions made by mutual written agreement between You and Us.

Filing a Complaint With the Maryland Insurance Administration

You or a health care provider filing a complaint on Your behalf may file a complaint with the Commissioner without first filing an Appeal with Us only if the coverage decision involves an urgent medical condition for which care has not been rendered.

Any person, including persons who have attempted to resolve an Appeal / Complaint through the Appeals Procedure and who are dissatisfied with the resolution, may, within sixty (60) working days after receipt of Our written appeal decision, file a Complaint with the Maryland Insurance Administration at the following address:

Consumer Complaint Unit
Maryland Insurance Administration
200 St. Paul Place – Suite 2700
Baltimore, MD 21202

Call Toll Free: 1-800-492-6116 or Local: 1-410-468-2244
FAX: 1-410-468-2260

Additionally, the Health Advocacy Unit is available to assist You in both mediating and filing an Appeal / Complaint under appeal / complaint process. The Health Advocacy Unit can be contacted at:

OFFICES OF THE ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION
HEALTH EDUCATION AND ADVOCACY UNIT

200 Saint Paul Place

Baltimore, Maryland 21202-2021

Health Advocacy Hot Line

(410) 528-1840

FAX (410) 576-6571

Toll Free 1-877-261-8807 (Mon-Fri 9:00 A.M. until 4:30 P.M.)

E-mail: Consumer@oag.state.md.us

Please include Your policy number in any communication with the above addresses.

SCHEDULE OF BENEFITS

Policyholder: Johns Hopkins University

An Insured Persons has the right to obtain vision care from the Provider of his or her choice. Benefits are payable as shown in the following Schedule of Benefits:

<u>Benefit</u>	<u>In-Network Costs</u>	<u>Out-of-Network Reimbursements</u>	<u>Benefit Frequency</u>
VISION EXAMINATION			
Comprehensive Eye Examination	\$10 Co-payment	up to \$40	12 months
VISION MATERIALS			
Standard Plastic Lenses			12 months
Single Vision	\$20 Co-payment	up to \$40	
Bifocal	\$20 Co-payment	up to \$60	
Trifocal	\$20 Co-payment	up to \$80	
Lenticular	\$20 Co-payment	up to \$80	
Frames	\$0 Co-payment, up to \$150 retail allowance	up to \$66	12 months
Contact Lenses (only one option available per Benefit Frequency)			12 months
Conventional	\$0 Co-payment, up to \$150 allowance	up to \$150	
Disposable	\$0 Co-payment, up to \$150 allowance	up to \$150	
Medically Necessary	\$0 Co-payment, Paid in full	up to \$210	
Lens Options			12 months
Standard Polycarbonate (For covered Dependent children under 19 years of age.)	\$0 Co-payment	up to \$32	
UV Treatment	\$0 Co-payment	up to \$12	
Tint: Solid or Gradient	\$0 Co-payment	up to \$12	
Standard Plastic Scratch Coating	\$0 Co-payment	up to \$12	
Standard Progressive Lenses (add on to Bifocal)	\$75 Co-payment	up to \$60	
Premium Progressive Lenses (add on to Bifocal)	Tier 1 \$105 Co-payment Tier 2 \$115 Co-payment Tier 3 \$130 Co-payment Tier 4 \$195 Co-payment	up to \$60	
Standard Anti-Reflective Coating	\$45 Co-payment	up to \$5	
Premium Anti-Reflective Coating	Tier 1 \$57 Co-payment Tier 2 \$68 Co-payment Tier 3 \$85 Co-payment	up to \$5	



COMBINED INSURANCE

Combined Insurance Company of America
111 Wacker Drive, Suite 700 • Chicago, Illinois 60601
Administrator's Office: 4000 Luxottica Place; Mason, OH 45040

DEPENDENT DEFINITION ENDORSEMENT

The rider is attached to and made part of Policy No. **1018944** issued by **Combined Insurance Company of America** to **Johns Hopkins University**.

Effective **January 1, 2019**, this Policy and Certificate as issued is amended as follows:

1. Replacing the Dependent Definition in the Definitions section with the following:

Dependent means any of the following persons whose coverage under the Policy is in force and has not ended:

1. the Insured's lawful spouse or Domestic Partner;
2. each child from birth to age 26; or
3. each child at least 26 years of age who is primarily dependent upon the Insured for support because the child is incapable of self support by reason of mental incapacity or physical incapacity that started before the child, grandchild, or individual under guardianship attained the limiting age; and was so incapacitated and is an Insured Person under the Policy on his or her 26th birthday; and who has been continuously so incapacitated since his or her 26th birthday; or
4. each child at least 26 years old who is a student and who is enrolled less than full time as a result of a documented disability that prevents the student from maintaining a full-time course load; and who is maintaining a course load of at least seven (7) credit hours per semester. The Company may request verification of the disability from a disability services professional employed by the institution of higher education that the student attends or a health care provider with special expertise in and knowledge of the disability.

Child includes stepchild, foster child, grandchild, legally adopted child, child legally placed in the Insured's home for adoption and child under the Insured's legal guardianship.

Any provision in the Policy and Certificate that provides coverage for a Dependent child up to a certain age is amended to cover such child to age 26, regardless of financial dependency, residency, student status, employment, marital status, or any combination of these factors.

Signed for **Combined Insurance Company of America**

Brad Bennett, President

Rebecca L. Collins, Secretary



ACE GROUP OF COMPANIES U.S. PRIVACY NOTICE

FACTS WHAT DOES THE ACE GROUP OF COMPANIES DO WITH YOUR PERSONAL INFORMATION?

Why?	Insurance companies choose how they share your personal information. Federal and state law gives consumers the right to limit some but not all sharing. Federal and state law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	<p>The types of personal information we collect and share depend on the product or service you have with us. This information can include:</p> <ul style="list-style-type: none"> ▪ Social Security number and payment history ▪ insurance claim history and medical information ▪ account transactions and credit scores <p>When you are no longer our customer, we continue to share information about you as described in this notice.</p>
How?	All insurance companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons insurance companies can share their customers' personal information; the reasons the ACE Group chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does ACE share?	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus	Yes	No
For our marketing purposes – to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes – information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For our affiliates to market to you	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?	Call 1-800-352-4462 or go to www.acegroup.com/us-en/contact-us/general-inquiry-form.aspx
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Who we are	
Who is providing this notice?	The ACE Group of Companies. A list of these companies is located at the end of this document.
What we do	
How does ACE Group protect my personal information?	<p>To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings.</p> <p>We restrict access to personal information to our employees, affiliates' employees, or others who need to know that information to service the account or to conduct our normal business operations.</p>
How does ACE Group collect my personal information?	<p>We collect your personal information, for example, when you</p> <ul style="list-style-type: none"> ▪ apply for insurance or pay insurance premiums ▪ file an insurance claim or provide account information ▪ give us your contact information <p>We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.</p>
Why can't I limit all sharing?	<p>Federal law gives you the right to limit only</p> <ul style="list-style-type: none"> ▪ sharing for affiliates' everyday business purposes – information about your creditworthiness ▪ affiliates from using your information to market to you ▪ sharing for nonaffiliates to market to you <p>State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.</p>
Definitions	
Affiliates	<p>Companies related by common ownership or control. They can be financial and nonfinancial companies.</p> <ul style="list-style-type: none"> ▪ Our affiliates include those with an ACE name and financial companies, such as Westchester Fire Insurance Company and ESIS, Inc.
Nonaffiliates	<p>Companies not related by common ownership or control. They can be financial and nonfinancial companies.</p> <ul style="list-style-type: none"> ▪ ACE does not share with nonaffiliates so they can market to you.
Joint Marketing	<p>A formal agreement between nonaffiliated financial companies that together market financial products or services to you.</p> <ul style="list-style-type: none"> ▪ Our joint marketing partners include categories of companies such as banks.

Other important information

For Insurance Customers in CA, CT, GA, IL, MA, ME, MN, MT, NC, NJ, OH, OR, and VA only: Under state law, you have the right see the personal information about you that we have on file. To see your information, write ACE US Customer Services, P.O. Box 1000, 436 Walnut Street, WA04B, Philadelphia, PA 19106. ACE USA may charge a reasonable fee to cover the costs of providing this information. If you think any of the information is wrong, you may write us. We will let you know what actions we take. If you do not agree with our actions, you may send us a statement. If you want a full description of privacy rights that we will protect in accordance with the law in your home state, please contact us and we will provide it. We may disclose information to certain third parties, such as law enforcement officers, without your permission.

For Nevada residents only: We may contact our existing customers by telephone to offer additional insurance products that we believe may be of interest to you. Under state law, you have the right to opt out of these calls by adding your name to our internal do-not-call list. To opt out of these calls, or for more information about your opt out rights, please contact our customer service department. You can reach us by calling **1-800-352-4462**, emailing us at info@acegroup.com, or writing to P.O. Box 1000, 436 Walnut Street, WA04B, Philadelphia, PA 19106. You are being provided this notice under Nevada state law. In addition to contacting ACE, Nevada residents can contact the Nevada Attorney General for more information about your opt out rights by calling 775-684-1100, emailing bcpinfo@ag.state.nv.us, or by writing to: Office of the Attorney General, Nevada Department of Justice, Bureau of Consumer Protection: 100 North Carson Street, Carson City, NV 89701.

For Vermont residents only: Under state law, we will not share information about your creditworthiness within our corporate family except with your authorization or consent, but we may share information about our transactions or experiences with you within our corporate family without your consent.

ACE Group of Companies legal entities

ACE Group of Companies use the names: ACE American Insurance Company, ACE Fire Underwriters Insurance Company, ACE Insurance Company of the Midwest, ACE Property and Casualty Insurance Company, Atlantic Employers Insurance Company, Bankers Standard Fire and Marine Company, Bankers Standard Insurance Company, Century Indemnity Company, Illinois Union Insurance Company, Indemnity Insurance Company of North America, Insurance Company of North America, Pacific Employers Insurance Company, Westchester Fire Insurance Company, Westchester Surplus Lines Insurance Company, ESIS, Inc., Combined Insurance Company of America, Combined Life Insurance Company of New York, Penn Millers Insurance Company, Agri General Insurance Company

**NOTICE CONCERNING
COVERAGE LIMITATIONS AND EXCLUSIONS
UNDER THE LIFE AND HEALTH INSURANCE
GUARANTY CORPORATION SUBTITLE**

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Maryland Life and Health Insurance Guaranty Corporation. The purpose of this is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Corporation will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty corporation is not unlimited, however. And, as noted in the box below, the protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Maryland Life and Health Insurance Guaranty Corporation may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in the state. You should not rely on coverage by the Maryland Life and Health Insurance Guaranty Corporation in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the Insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Corporation to induce you to purchase any kind of insurance policy.

**The Maryland Life and Health Insurance
Guaranty Corporation
9199 Reisterstown Road
P.O. Box 671 - Suite 216C
Owings Mills, Maryland 21117
(410) 998-3907**

The state law that provides for this safety-net coverage is called the Maryland Life and Health Insurance Guaranty Corporation Act.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

Following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the law or the rights or obligations of the guaranty corporation.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Corporation if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are NOT protected by this Corporation if:

- they are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state;
- the insurer was not authorized to do business in this state;
- their policy was issued by a Health Maintenance Organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessment, or by an insurance exchange.

The Corporation also does NOT provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance unless assumption certificates have been issued;
- interest rate yields that exceed an average rate;
- any portion of a policy or contract to the extent that it provides dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The statute also limits the amount that the corporation is obligated to pay. The Corporation cannot pay more than the amount the insurance company would owe under a policy or contract. Also, with respect to any one life, regardless of the number of policies or contracts with the member insurer, the corporation will pay maximum of \$300,000 even if the policies or contracts provide different types of coverage. Within this overall \$300,000 limit, the corporation will not pay more than \$100,000 in cash surrender values, \$300,000 in health insurance benefits, \$100,000 in present value of annuities, or \$300,000 in life insurance death benefits -- again, no matter how many policies and contracts the insured has with the member company, and no matter how many different types of coverage.


COMBINED INSURANCE COMPANY OF AMERICA

111 Wacker Drive, Suite 700 • Chicago, Illinois 60601
 Administrator's Office: 4000 Luxottica Place; Mason, OH 45040

Application for Vision Care Benefits
I. GROUP INFORMATION

 Group Name: Johns Hopkins University Tax ID#: 52-0595110

 DBA Name (if other than above): Johns Hopkins University

 Business Address: 1101 E 33rd St Ste D200 City: Baltimore State: MD ZIP: 21218-3637

 Mailing Address: 1101 E. 33rd Street City: Baltimore State: MD ZIP: 21218

Primary Contact: _____ Title: _____

Phone Number: _____ Fax Number: _____

E-mail Address: _____

 Type of Business: Proprietorship Corporation Other (Specify): Higher Education

 Service Area: National (United States does not include Puerto Rico) State Specific (List) _____

PLEASE NOTE THE FOLLOWING TYPES OF BUSINESS PRIOR APPROVAL FROM CARRIER:
 MEWA PEO Trust Union

 If any subsidiary or affiliated companies are to be insured or any Employees/Members are working at a location other than the address above, please explain. n/a

 Billing Contact Name: Chad Kersey Phone: 4439975810

 Billing Address: 1101 E. 33rd Street C020 City: Baltimore State: MD ZIP: 21218

 If you have subsidiaries, affiliated companies, or divisions who use another name and will be covered by this plan, AND require separate billing invoices, please attach the following information on a separate sheet of paper signed by you:

- Name
- Address
- Billing Contact and Phone Number

 Will this plan replace any existing coverage? Yes No

If "Yes," indicate name and address of existing insurer:

 Name: United HealthCare Address: PO Box 30978

 City: Salt Lake City State: Ut ZIP: 84130

 Effective date of existing coverage: 1/1/2018

 Termination date of existing coverage (if applicable): 12/31/2018

 If "Yes," are any Employees/Members on COBRA continuation? Yes No How many? _____

 Do you intend to offer Employees/Members COBRA Continuation? Yes No

II. PLAN SELECTION

Please refer to the attached proposal page. Services are provided by EyeMed Vision Care.

III. PREMIUMS

 Contribution towards premium Yes No

Group's Premium Contribution for*: Employees/Members: 0 % Dependents: 0 %
Employee's/Member's Premium Contribution for: Employees/Members: 100 % Dependents: 100 %
Are Employee/Member and Dependent premiums paid through a Section 125 Plan? Yes No
Are Employee/Member and Dependent premiums collected via payroll deduction? Yes No

Premiums shall be at the rates included on the attached proposal page.

**If the Group's contribution percentage is changed or the number of eligible Employees/Members increases or decreases, premium may be adjusted as allowed under the Policy. The premium may be adjusted at the end of the calendar month in which the change occurred.*

IV. ELIGIBILITY

Number of Employees/Members: 16619 Number Applying: _____
Number of Dependents: _____ Number of Retirees: 0
Are Domestic Partners covered under this Plan? Yes No
Same Sex*? Yes No Opposite Sex*? Yes No
Dependent Children Covered to Age** 19 21 25 Other 26
Dependent Children Covered if Full-Time Student** Yes No
If "Yes", Dependent Full-Time Student Covered to** 21 25 27 Other 26

**Except as required by state law.
**Unless state law has different requirements for Dependent Child status.*

Eligibility Reporting Contact (produces the eligibility file): Sue Nayden
Address (if different from group): n/a
City: n/a State: na ZIP: 21218
E-mail Address: snayden1@jhmi.edu Phone Number: 6672086440 Fax Number: _____
Eligibility Authorization Contact (Benefits Administrator or Third Party Administrator responsible for verifying vision election for Employees/Members):
Name: Benefits Service Center Phone: 4105162000
Days/Hours of Availability: 8:30-5 E-mail Address: benefits@jhu.edu

PROBATIONARY PERIOD

For New Employees/Members: 30 days 60 days 90 days 180 days Other 0
Probationary Period is waived for present Employees/Members: Yes No
Number of Employees/Members who have not yet completed the probationary period: 0

V. EFFECTIVE DATE

This plan will become effective at 12:01 a.m. Local Time at the Group's address herein, on the first day of 1/1, 2019, provided all of the following have been completed prior to the effective date:

- A. This application has been received and accepted by the Company (must be submitted 30 days in advance of the effective date).
- B. EyeMed has been furnished a working file of all eligible Employees/Members, according to the layout guidelines. It is understood and agreed that EyeMed may rely on this information to provide services to individuals designated as eligible.

The Group hereby makes application to Combined Insurance Company of America for Vision Care Benefits. The Group agrees to maintain and furnish any records necessary to administer this plan and to forward premiums monthly.

The Group certifies that all the information shown on this application and any attachments are correct and complete as of the date this application is signed. The Group understands that the Company intends to rely on this information in determining whether or not the enrolling Employees/Members and their Dependents may become insured. It is further understood and agreed that **NO INSURANCE WILL BECOME EFFECTIVE UNTIL APPROVED BY THE COMPANY**; and that no field representative of the Company has the authority to modify any conditions of the application or the Policy by making any promise or representation. It is understood that the insurance as to any Employee/Member will not become effective on the date insurance should otherwise become effective if he or she is not at work on such date performing all duties of his or her occupation and otherwise meets the requirements of the Company.

I hereby represent that I have reviewed the fraud warning notice below:

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at: _____ this 1st _____ day of _____, 20 18

Signed for the Group: X Heidi Conway Title: Vice President/Chief HR Officer

VI. COMPANY DISPLAY NAME

Company Name: The Johns Hopkins University
(Maximum of 30 characters, including punctuation and spacing)

ATTENTION: THE DEPARTMENT OF INSURANCE REQUIRES THAT ONLY ONLY BROKER AND/OR GENERAL AGENT WHO SOLD THE PRODUCT AND HOLDS A VALID LIFE AND HEALTH LICENSE MAY COMPLETE THE CERTIFYING STATEMENT

WRITING BROKER'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the applicant and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): EyeMed Vision Care Tax ID No.: 31-1656473

Broker Name (print): Daneen Seifert SS#: _____

Address: 4000 Luxottica Pl City: Mason State: OH ZIP: 45040

Phone: 410-215-0337 Fax: _____

Primary Contact: Daneen Seifert

Secondary Contact: _____

Title: _____

Title: _____

E-mail Address: DSeifert@eyemed.com

E-mail Address: _____

Commission checks payable to: Firm Broker

Broker Signature: X Daneen Seifert

WRITING GENERAL AGENT'S CERTIFYING STATEMENT

I certify that I have accurately recorded on this application the information supplied by the applicant and I am properly licensed in the state in which the Group is domiciled.

Firm Name (print): _____ Tax ID No.: _____

General Agent Name (print): _____ SS#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Primary Contact: _____

Secondary Contact: _____

Title: _____

Title: _____

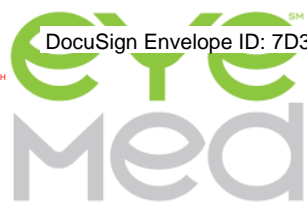
E-mail Address: _____

E-mail Address: _____

Commission checks payable to: Firm

General Agent

General Agent's Signature: **X** _____



Proposed Benefits

EyeMed Vision Care in conjunction with Combined Insurance Company of America
 Option Alternate 121212
 Exam and Materials
 Insight Network
 Fully Insured
 Employee Paid
 Funded Benefits

Frequency

Examination
 Once every 12 months
Lenses (in lieu of contact lenses)
 Once every 12 months
Contacts (in lieu of lenses)
 Once every 12 months
Frame
 Once every 12 months

Vision Care Services	Member Cost In-Network	Out of Network Member Reimbursement up to:
Exam <i>With Dilation as Necessary</i>	\$10 Copay	\$40
Frames <i>Any available frame at provider location</i>	\$0 Copay; \$150 allowance, 20% off balance over \$150	\$66
Contact Lenses <i>(Contact Lens allowance includes materials only)</i>		
Conventional	\$0 Copay, \$150 allowance, 15% off balance over \$150	\$150
Disposable	\$0 Copay, \$150 allowance, plus balance over \$150	\$150
Medically Necessary	\$0 Copay, Paid-In-Full	\$210
Standard Plastic Lenses		
Single Vision	\$20 Copay	\$40
Bifocal	\$20 Copay	\$60
Trifocal	\$20 Copay	\$80
Lenticular	\$20 Copay	\$80
Standard Progressive	\$75 Copay	\$60
Premium Progressive Tier 1	\$105 Copay	\$60
Premium Progressive Tier 2	\$115 Copay	\$60
Premium Progressive Tier 3	\$130 Copay	\$60
Premium Progressive Tier 4	\$195 Copay	\$60
Covered Lens Options		
Standard Anti-Reflective	\$45 Copay	\$5
Premium Anti-Reflective Tier 1	\$57 Copay	\$5
Premium Anti-Reflective Tier 2	\$68 Copay	\$5
Premium Anti-Reflective Tier 3	\$85 Copay	\$5
Standard Polycarbonate - under age 19	\$0 Copay	\$32
Standard Plastic Scratch Coating	\$0 Copay	\$12
UV Treatment	\$0 Copay	\$12
Tint (Solid & Gradient)	\$0 Copay	\$12
Monthly Rate		
Subscriber	\$4.90	
Subscriber + 1	\$8.81	
Subscriber + Family	\$13.87	

All plans are based on a 48-month contract term and 48-month rate guarantee
 Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies
 EyeMed Vision Care reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers.
 For current listing of brands by tier, visit <http://www.discovereyemed.com>

Plan Details
 Quote for group situated in the State of MD and will be valid until the 1/1/2019 implementation date. Date Quoted 4/30/2018. Benefit allowances provide no remaining balance for future use within the same benefit frequency. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Percentage discounts are not part of the insurance benefit. Insured benefits are underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York.

Plan Exclusions
 No benefits will be paid for services or materials connected with or changes arising from:
 -orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
 -medical and/or surgical treatment of the eye, eyes or supporting structures;
 -any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
 -services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
 -plano (non-prescription) lenses;
 -non-prescription sunglasses;
 -two pair of glasses in lieu of bifocals;
 -services or materials provided by any other group benefit plan providing vision care;
 -services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and services rendered to the Insured Person are within 31 days from the date of such order; or
 -lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting EyeMed by mail, email, or telephone. If Johns Hopkins University has chosen this benefit design, attach this document to the group application and sign here:

Audi Conway _____ 10/1/2018 | 4:12 PM EDT
 Signature Date