



COMPBENEFITS INSURANCE COMPANY

P. O. Box 14313

Lexington, KY 40512-4313

(866) 537-0229

**CERTIFICATE
OF
GROUP VISION INSURANCE**

This Certificate outlines the features of the Group Vision Insurance Policy issued to the Policyholder by CompBenefits Insurance Company (hereinafter referred to as “CompBenefits”). Read it carefully to become familiar with Your coverage. In this Certificate, the masculine pronouns include both masculine and feminine gender unless the context indicates otherwise. Your coverage may be terminated or amended in whole or in part under the terms and provisions of the Policy.

If you should have any questions, or to obtain coverage information or assistance in resolving complaints, please call (866) 537-0229.

Signed for CompBenefits Insurance Company

A handwritten signature in black ink, appearing to read 'Gerald L. Ganoni', is positioned above a horizontal line.

Gerald L. Ganoni
President

SECTION I- DEFINITIONS

Copayment- means the amount an Insured is required to pay when a covered service is rendered or covered Materials are purchased.

Dependent- means any of the following persons:

1. Your spouse;
2. Your unmarried children or grandchildren;
 - a) from birth to age 26 and dependent upon You for support; or
 - b) at least 26 years of age and:
 - i. primarily dependent upon You for support because of mental or physical handicap;
 - ii. was incapacitated and insured under the Certificate on his 26th birthday; and
 - iii. continues to be incapacitated beyond his 26th birthday.

A child also includes adopted children, as well as stepchildren or foster children living with the Subscriber in a parent-child relationship.

Group- means the aggregate of individuals eligible to be covered under the Policy. Group also refers to the subgroup participating under the Policy for the benefit of its group members.

Insured- means You and Your Dependent(s) covered under the Policy.

Materials- means lenses, frame and contact lenses covered under the Policy.

Non-VisionCare Plan Network Provider- means any provider who is NOT under agreement with the VisionCare Plan Network.

Policy- means the Policy issued to the Policyholder.

Policyholder – means the Group to whom the Policy has been issued.

Schedule of Benefits - means the listing of benefits showing what is paid.

“**You**” and “**Your**” means the Certificateholder.

VisionCare Plan Network- means jointly and severally the VisionCare Plan Network Providers under agreement with Us to provide certain vision services to individuals at contracted rates and terms.

VisionCare Plan Network Provider- means a provider under agreement with VisionCare Plan Network.

“**We**”, “**Our**”, “**Us**”, and “**Plan**” means CompBenefits.

SECTION II-BECOMING INSURED

Your Coverage Begins- You and Your Dependents are covered at 12:01 a.m. on the later of:

1. The first of the month following the date first eligible for coverage;
2. The date We accept Your enrollment, if You are not enrolled within 30 days of becoming eligible;
3. The date You first acquire a new Dependent;
4. The date We accept a Dependent’s enrollment, if he is not enrolled within 30 days of becoming eligible.

Newborn Child- A child born to You or Your Dependent spouse is covered from the moment of birth for 30 days. If you choose to insure Your newborn, You must enroll the child within 30 days from the date of birth and pay the additional premium, if any, or coverage for that child will terminate at the end of the 30-day period.

Adopted Child- A child placed with You for adoption will be covered from the earlier of: 1) the date of birth if a petition for adoption is filed within 30 days of the birth of such child; 2) the date you gain custody of the child under a temporary court order that grants You conservatorship of the child; or 3) the date the child is placed with You for adoption; and additional premium, if any, is paid.

Your Coverage Ends- Coverage for You and/or Your Dependent will end at 12:01 a.m. on the earlier of:

1. On the date the Policyholder tells Us that You and/or Your Dependent cease to be eligible for coverage;
2. The last day of the month in which Your Dependent is no longer a Dependent as defined;
3. Subject to the Grace Period provision, the last day of the month for which a premium has been paid; or
4. The date coverage ends for any class or Group to which You belong; or
5. The date the Policy ends.

If Your coverage ends it will not prejudice any existing claim. If service is being rendered at the time coverage ends for an Insured, We will continue to reimburse for such service to completion, but in no event beyond a 3-month period following the date coverage ended.

SECTION III-PROCEDURES FOR USING BENEFITS

Provider Choice - The Insured may elect to receive services and Materials from either a VisionCare Plan Network Provider or a Non-VisionCare Plan Network Provider of his or her choice. When receiving services from a Non-VisionCare Plan Network Provider, You must obtain an Out-of-Network Claim Form located On our web site www.myhumanavisioncare.com or You may call Customer Care at (866) 537-0229 and have the form mailed to You.

Using a VisionCare Plan Network Provider – Prior to receiving services, log on to our website at www.humanavisioncare.com or call Customer Care (866) 537-0229 to obtain a list of participating VisionCare Plan Network Providers and to confirm Your eligibility for benefits under the Plan.

Once You have verified that the provider is a participating VisionCare Plan Network Provider and confirmed that You are eligible for benefits, please contact the provider to schedule an appointment. You must identify yourself as a VisionCare Plan member, have your group name and policy number available. The VisionCare Plan Network Provider will provide the covered service and bill the Plan directly. You will pay your Copayment and any extra costs for services and materials not covered by the Plan.

In the event You receive a prescription for corrective eyewear from the examining VisionCare Plan Network Provider, You may obtain Materials from that provider or another participating VisionCare Plan Network Provider.

Using a Non-VisionCare Plan Network Provider - When an Insured elects to obtain services or purchase Materials from a Non-VisionCare Plan Network Provider, payment of benefits are based upon the VisionCare Plan Network allowance after deduction of the Copayment. The allowance and Copayment are shown in the Schedule of Benefits. The Insured must pay the Non-VisionCare Plan Network Provider in full for any service and/or Materials at the time the service is rendered or the Materials are provided and then submit to Us an itemized statement of charges. The Insured is responsible for payment of the Copayment, the costs and fees associated with covered services or Materials in excess of the allowance as shown in the Schedule of Benefits, and any services or materials NOT covered by the Policy.

SECTION IV-LIMITATIONS AND EXCLUSIONS

Limitations- In no event will coverage exceed the lesser of:

1. The actual cost of covered services or Materials;
2. The limits of the Policy, shown in the Schedule of Benefits; or
3. The allowance as shown in the Schedule of Benefits.

Materials covered by the Policy that are lost or broken will only be replaced at normal intervals as provided for in the Schedule of Benefits.

We will pay only for the basic cost for lenses and frames covered by the Policy. The Insured is responsible for extras selected, including but not limited to:

1. Blended lenses;
2. Progressive multifocal lenses;
3. Photochromatic lenses; tinted lenses, sunglasses, prescription and plano;
4. Coating of lens or lenses;
5. Laminating of lens or lenses;
6. Groove, Drill or Notch, and Roll and Polish;
unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

Exclusions- We will not cover:

1. Orthoptic or vision training and any associated supplemental testing;
2. Two pair of glasses, in lieu of bifocals, trifocals or progressives;
3. Medical or surgical treatment of the eyes;
4. Any services and/or materials required by an Employer as a condition of employment;
5. Any injury or illness covered under any Workers' Compensation or similar law;
6. Sub-normal vision aids, aniseikonic lenses or non-prescription lenses;
7. Charges incurred after: (a) the Policy ends; or (b) the Insured's coverage under the Policy ends, except as stated in the Policy;
8. Experimental or non-conventional treatment or device;
9. Contact lenses, except as specifically covered by the Policy;
10. Hi Index, aspheric and non-aspheric styles;
11. Oversized 61 and above lens or lenses;
12. Cosmetic items, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

SECTION V-COORDINATION WITH OTHER BENEFITS

1. APPLICABILITY.

This Coordination With Other Benefits provision applies to This Plan when You or Your covered dependents have vision care coverage under more than one Plan. For the purposes of this section only, "Plan" and "This Plan" are defined below. If this provision applies, the Order of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan: (a) will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but (b) may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in Section 4, Effect on the Benefits of This Plan.

2. DEFINITIONS.

A "Plan" is any group insurance or group type insurance, whether insured or uninsured, which provides benefits for, or because of, vision care or treatment. This also includes 1) group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; and 2) group coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or self insured employee benefit plans. It does not include school accident type coverages, coverage under any governmental plan required or provided by law, or any state plan under Medicaid. Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and coordination applies only to one of the two, each of the parts is a separate Plan.

"This Plan" means this Policy.

"Primary Plan"/"Secondary Plan". The Order of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expenses" means the allowed amount as shown in the Schedule of Benefits.

"Claim Determination Period" means a benefit year. However it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this provision or a similar provision takes effect.

3. ORDER OF BENEFIT DETERMINATION RULES.

This Plan determines its order of benefits using the first of the following rules which applies:

- (a) The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as other than a dependent, then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent. Except in the case of legal separation or divorce (further described below), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":
 - (1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
 - (2) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. However, if the other Plan does not have the rule described immediately above, and if, as a result, the Plans do not agree on the Order of Benefits, the rule in the other Plan will determine the order of benefits.
- (b) If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order: (1) first, the Plan of the parent with custody of the child; (2) then, the Plan of the spouse of the parent with custody of the child; and (3) finally, the Plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- (c) The benefits of a Plan which covers a person as an employee who is neither laid off, retired or continuing coverage under a right of continuation (or as a dependent of the person) are determined before those of a Plan which covers that person as a laid off, retired or continuing coverage (or as a dependent of that person). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the Order of Benefits, this rule is ignored.
- (d) If none of the above rules determines the Order of Benefits, the benefits of the Plan which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

4. EFFECT ON THE BENEFITS OF THIS PLAN.

This section applies when, in accordance with Section 3. Order of Benefit Determination Rules, This Plan is a Secondary Plan to one or more other Plans. In the event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the Other Plans".

The benefits of This Plan will be reduced when the sum of: (a) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this provision; and (b) the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision,

whether or not claim is made; exceeds those Allowable in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these rules. CompBenefits has the right to decide which facts are needed. CompBenefits may get needed facts from, or give them to, any other organization or person. CompBenefits need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give CompBenefits any facts deemed necessary to pay the claim.

6. FACILITY OF PAYMENT.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, CompBenefits may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. CompBenefits will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case, "payment made" means reasonable cash value of the benefits provided in the form of services.

7. ERRORS RELATED TO YOUR COVERAGE.

The Plan has the right to correct benefit payments made in error. Providers and/or You have the responsibility to return any overpayments to the Plan. The Plan has the responsibility to make additional payment if any underpayments have been made.

SECTION VI-PREMIUMS

Premium Payments - All premiums are payable in advance for coverage under the Policy on the first day of each calendar month in accordance with the premium rate schedules of CompBenefits in effect for each premium due date.

Grace Periods - A grace period of 31 days is allowed for payment of each premium due after the first premium, during such grace period the Policy shall continue in force, unless the Group has given the Plan written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the Policy. If any premium is not paid prior to the end of the grace period, the coverage to which the premium applies will lapse at the end of the grace period. We will charge a pro-rata premium for the time coverage under the Policy remained in force for any Group during such grace period.

Change in Premiums - Premiums are payable to CompBenefits or Our authorized agent. Premiums may be increased for a Policy period on the anniversary date of the Policy. Notice of the maximum amount of a premium increase will be mailed to the Policyholder not less than 90 days prior to the anniversary of the Policy period.

Reinstatement - If any renewal premium is not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by CompBenefits or by any agent authorized by CompBenefits to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, that if CompBenefits or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by CompBenefits, or lacking approval, upon the forty-fifth day following the date of such conditional receipt unless CompBenefits has previously notified the Policyholder in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects, the Policyholder and CompBenefits shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Termination - This Policy may be terminated if CompBenefits elects to discontinue offering this type of group insurance coverage by this form of Policy or if CompBenefits elects to discontinue all types of coverage, in accordance with applicable state and federal laws. You will receive at least one hundred-eighty (180) days advance notice prior to such discontinuance. Unless otherwise permitted under state law, except for nonpayment of the required premium or the failure to meet continued underwriting standards, CompBenefits will not terminate this Policy prior to the first anniversary date of the Effective Date of the Policy as specified herein. Termination by CompBenefits will be without prejudice to any expenses originating prior to the effective date of termination.

This section does not apply to a termination for nonpayment of premium by the Policyholder. In the event that the Policyholder fails in a timely manner to pay premiums, the Policy will terminate on the last date for which premium was paid.

SECTION VII-CLAIMS

Notice of Claim - Written notice of claim must be given to Us within 60-days after the occurrence or commencement of loss covered by the Policy, or as soon thereafter as reasonably possible. Notice given by or on behalf of You or Your beneficiary to Us at P.O. Box 14313, Lexington, KY 40512-4313, or to Our authorized agent, with information sufficient to identify the Insured, shall be deemed notice to Us.

Claim Forms- You can get the forms You need for claiming benefits by calling Us at (866) 537-0229 or writing Us at P.O. Box 14313, Lexington, KY 40512-4313. If the forms are not sent to You before the expiration of 15 days after the giving of notice, You shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

Time of Payment of Claims - Indemnities payable under this Policy for any loss, other than loss for which the Policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which the Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

Proof of Loss – Written proof of loss must be furnished to Us at P.O. Box 14313, Lexington, KY 40512-4313 in the case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss within 90-days after the termination period for which We are liable and, in the case of claim for any other loss, within 90-days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Legal Action - No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

SECTION VIII- NOTICE OF CONTINUATION OF GROUP HEALTH COVERAGE RIGHTS (COBRA) FOR GROUPS SIZE 20 OR MORE

If Your insurance terminates in accordance with the other terms of this Policy, it will be reinstated as of the date of termination if You elect to continue the insurance in force as described in this section. You may elect to continue insurance if You are currently insured under this Policy, and if such insurance is terminating due to any of the following Qualifying Events:

1. Termination of Your employment (for reasons other than gross misconduct);
2. Reduction of work hours including lay-off;
3. Death of the Certificateholder;
4. Divorce or legal separation;

5. A child ceases to be a dependent as defined in this Policy;
6. The Policyholder files for a Chapter 11 bankruptcy petition, and as a result to this You suffer a loss of coverage under Your retiree coverage.

The maximum continuation of coverage period with respect to a reason described above is: (1) 18 months with respect to 1 or 2 above. However, if You are disabled as determined under Title II or XVI of the Social Security Act at the time of the Qualifying Event or any time during the first 60 days of continuation coverage, then You and any other non-disabled eligible individuals will be eligible for an additional 11 months; (2) 36 months with respect to 3, 4 or 5 above; (3) With respect to 6 above, lifetime coverage for You, whereas Your Dependents will be covered until the earlier of: (a) Your death; or (b) death of the Dependent. If, while insurance is being continued, further qualifying events occur which would entitle You to again elect continuation, the total period of continuation may not exceed 36 months from the date the initial continuation commenced, other than the coverage due to bankruptcy filing as described above.

It is Your responsibility to notify the Policyholder of the occurrence of a Qualifying Event other than termination of employment or reduction in work hours. You must notify the Policyholder within 60 days.

It is the responsibility of the Policyholder to provide You with written notice of Your right to continue coverage under this Section. Such notice will also contain the amount of monthly premium You must pay to continue coverage and the time and manner in which such payments must be made.

To continue coverage under this Policy You must notify the Policyholder of Your election within 60 days of the latest of: (1) the date of Qualifying Event; (2) the date of the loss of coverage; or (3) The date the Policyholder sends notice of the right to continue coverage.

Payment for the cost of insurance for the period preceding the election must be made to the Policyholder within 45 days after the date of such election. Subsequent payments are to be made to the Policyholder in the manner described by the Policyholder in the notice. The Policyholder will remit the payments to CompBenefits.

Continuation of insurance will terminate at the earliest of the following dates: (1) The end of the maximum continuation of coverage period; (2) The last day of the period of coverage for which premiums have been paid, if You fail to make a premium payment when due; (3) Your becoming covered under another group vision care plan as employee, spouse or dependent child; however, coverage will continue for a pre-existing condition for which treatment has already commenced and which is excluded or limited by the other group vision plan; (4) Discontinuance of this vision care benefit provision; or (5) The date Your employer ceases to provide any group vision plan.

SECTION IX-GENERAL PROVISIONS

Representations and Warranties - All statements made by any Insured or the Group are deemed representations and not warranties. No statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to You, or in the event of Your death or incapacity, Your beneficiary or personal representative.

Worker's Compensation Act - The coverage under the Policy is not in lieu of and does not affect any requirement for coverage by any Worker's Compensation Act, or other similar legislation.

Conformity with State Statutes - Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Time Limit on Certain Defenses - After the Policy has been in force for a period of two (2) years during the lifetime of the Insured, excluding any period during which the Insured is disabled, it shall become incontestable as to the statements contained in the application.

Notice of Independent Contractor Relationship – The Plan assumes responsibility of fulfilling the terms of this Certificate. VisionCare Plan Network Providers are independent contractors, and the Plan cannot be held responsible for any damages incurred as a result of tort, negligence, breach of contract, or malpractice by a VisionCare Plan Network Provider for any damage which result from any defective or dangerous condition in or about any facility which services are rendered or materials are provided hereunder.

SCHEDULE OF BENEFITS

Vision Examinations - Each Insured is eligible for a comprehensive eye examination which shall include: 1) personal and family medical and ocular history; 2) visual acuity (unaided or acuity with present correction); 3) external exam; 4) pupillary exam; 5) visual field testing (confrontation); 6) internal exam (direct or indirect ophthalmoscopy recording cup disc ratio, blood vessel status and any abnormalities; 7) biomicroscopy (i.e. cover test); 8) tonometry; 9) refraction (with recorded visual acuity); 10) extra ocular muscle balance assessment; 11) diagnosis and treatment plan. We will cover such service once in any **12 month** period.

Materials - Where the vision examination shows new lenses or frames or both are necessary for proper visual health, such Materials will be covered, together with certain services as necessary. Services include, but are not limited to: (1) prescribing and ordering proper lenses; (2) assisting with selection of frames; (3) verifying accuracy of finished lenses; (4) proper fitting and adjustments.

Lenses - One pair of prescription lenses once in any **12 month** period.

The following lens options are covered at **100% after copay**. The VisionCare Plan Network Provider will show the Insured the lens options that the Plan covers.

Level I progressive lenses
Level II progressive lenses

Frames - One new frame once in any **12 month** period. The VisionCare Plan Network Provider will show the Insured the frames that the Plan covers in full. VisionCare Plan Providers can also order any currently provided frame that an Insured may find elsewhere. If an Insured selects a frame that costs more than the amount the Plan covers, the Insured is responsible for the difference in cost.

Contact lenses when necessary – One pair of contact lenses under the following circumstances and only if prior authorization from the Plan is obtained: 1) following cataract surgery without intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) Anisometropia greater than 5.00 diopters and asthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life. Replacement will not be more often than once in any **12 month** period and only if prior authorization is obtained from the Plan.

Contact lenses when elective - Benefits include: (1) the cost of an annual vision examination. Such benefit is subject to the Copayment (2) the cost of contact lenses available from a selection provided by a VisionCare Plan Network Provider, not subject to the Copayment; and (3) the cost of contact lenses, any fitting cost and follow-up visit up to a maximum of **\$150.00**, not subject to the Copayment. This benefit is in lieu of all other benefits and not available when benefits for eyeglasses are received. Replacement will not be more often than once in any **12 month** period.

Co-Payment - An Insured's Co-payment is:

- | | | |
|----|--------------------|-------------|
| 1. | Vision Examination | \$20 |
| 2. | Materials | \$25 |

Allowance – Vision benefits received from Non-VisionCare Plan Network Providers will be reimbursed according to the following schedule.

Vision Examination		\$35
Single Vision Lens		\$25
Bifocal Lens		\$40
Trifocal Lens		\$60
Lenticular Lens		\$100
Contact Lenses when elective	Exam +	\$150
Contact Lenses when necessary		\$210
Frame		\$40
New Case		\$ 0

WHEN COVERED SERVICES ARE OBTAINED FROM A VISIONCARE PLAN NETWORK PROVIDER, THE INSURED IS ONLY RESPONSIBLE FOR THE CO-PAYMENT AMOUNT LISTED ABOVE.

WHEN SERVICES ARE OBTAINED FROM A NON-VISIONCARE PLAN NETWORK PROVIDER, PAYMENT OF BENEFITS ARE BASED UPON THE VISIONCARE PLAN ALLOWANCE.

**IMPORTANT INFORMATION ABOUT COVERAGE UNDER
THE TEXAS LIFE-AND HEALTH-INSURANCE GUARANTY ASSOCIATION
(For insurers declared insolvent or impaired on or after September 1, 2011)**

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association (“the Association”), administers this protection system. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

IT IS POSSIBLE THAT THE ASSOCIATION MAY NOT COVER ALL OR PART OF YOUR POLICY BECAUSE OF STATUTORY LIMITATIONS.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- **Residents of Texas (regardless of where the policyholder lived when the policy was issued);**
- **Residents of other states, ONLY if the following conditions are met:**
 1. The policyholder has a policy with a company domiciled in Texas;
 2. The policyholder's state of residence has a similar guaranty association; and
 3. The policyholder is **not eligible** for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of \$500,000 for basic hospital, medical-surgical, and major medical insurance, \$300,000 for disability or long term care insurance, or \$200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of \$100,000 under one or more policies on a single life; or
- Death benefits up to a total of \$300,000 under one or more policies on any one life; or
- Total benefits up to a total of \$5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of \$250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to \$250,000 on any one life; or
- Present value of unallocated benefits up to \$5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- \$300,000 on any one life with the exception of the \$500,000 health insurance limit, the \$5,000,000 multiple owner life insurance limit, and the \$5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health
Insurance Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or
www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or
www.tdi.texas.gov

Notices

The following pages contain important information about Humana's claims procedures and certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. There may also be differences between this notice packet and state law. The Plan participant is eligible for the rights more beneficial to the participant.

This section includes notices about:

Claims and Appeal Procedures

Federal Legislation

Medical Child Support Orders

Continuation of Coverage for Full-time Students During Medical Leave of Absence

General Notice of COBRA Continuation of Coverage Rights

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

Family and Medical Leave Act (FMLA)

**Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
~Your Rights under ERISA**

Privacy and Confidentiality Statement

CLAIMS AND APPEALS PROCEDURES

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures. Humana complies with these standards. Covered persons in insured plans subject to ERISA should also consult their insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage). Humana complies with the requirements set forth in any such benefit plan document issued by it with respect to the plan unless doing so would prevent compliance with the requirements of the federal ERISA statute and the regulations issued thereunder. The following claims procedures are intended to comply with the ERISA claims regulation, and should be interpreted consistent with the minimum requirements of that regulation. Covered persons in plans not subject to ERISA should consult their benefit plan documents for the applicable claims and appeals procedures.

DISCRETIONARY AUTHORITY

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

1. Interpret plan provisions;
2. Make decisions regarding eligibility for coverage and benefits; and
3. Resolve factual questions relating to coverage and benefits.

CLAIMS PROCEDURES

Definitions

Adverse determination: means a decision to deny benefits for a pre-service claim or a post-service claim under a group health and/or dental plan.

Claimant: A covered person (or authorized representative) who files a claim.

Concurrent-care Decision: A decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the plan (other than by plan amendment or termination) or a decision with respect to a request by a Claimant to extend a course of treatment beyond the period of time or number of treatments that has been approved by the plan.

Group health plan: an employee welfare benefit plan to the extent the plan provides dental care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

Health insurance issuer: the offering company listed on the face page of your Certificate of Insurance or Certificate of Coverage and referred to in this document as "Humana."

Post-service Claim: Any claim for a benefit under a group health plan that is not a Pre-service Claim.

Pre-service Claim: A request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Urgent-care Claim (expedited review): A claim for covered services to which the application of the time periods for making non-urgent care determinations:

could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an Urgent-care Claim. However, any claim a physician, with knowledge of a covered person's medical condition, determines is a "Urgent-care Claim" will be treated as a "claim involving urgent care."

Submitting a Claim

This section describes how a Claimant files a claim for plan benefits.

A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. Claims will be not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

- Name of the covered person who incurred the covered expense.
- Name and address of the provider
- Diagnosis
- Procedure or nature of the treatment
- Place of service
- Date of service
- Billed amount

A general request for an interpretation of plan provisions will not be considered a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the plan, should be directed to the plan administrator.

Procedural Defects

If a Pre-service Claim submission is not made in accordance with the plan's requirements, Humana will notify the Claimant of the problem and how it may be remedied within five (5) days (or within 24 hours, in the case of an Urgent-care Claim). If a Post-service Claim is not made in accordance with the plan's requirement, it will be returned to the submitter.

Authorized Representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

- Any document designating an authorized representative must be submitted to Humana in advance or at the time an authorized representative commences a course of action on behalf of the covered person. Humana may verify the designation with the covered person prior to recognizing authorized representative status.
- In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an Urgent-care Claim will be recognized by the plan as the covered person's authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. Circumstances may arise under which an authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims Decisions

After a determination on a claim is made, Humana will notify the Claimant within a reasonable time, as follows:

Pre-service Claims

Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives the claim.

This period may be extended by an additional 15 days, if Humana determines the extension is necessary due to matters beyond the control of the plan. Before the end of the initial 15-day period, Humana will notify the Claimant of the circumstances requiring the extension and the date by which Humana expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the Claimant will have at least 45 days from the date the notice is received to provide the necessary information.

Urgent-care Claims (expedited review)

Humana will determine whether a particular claim is an Urgent-care Claim. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a Claimant to clarify the medical urgency and circumstances supporting the Urgent-care Claim for expedited decision-making.

Notice of a favorable or *adverse determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 72 hours after receiving the Urgent-care Claim.

If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the Claimant as soon as possible, but not more than 24 hours after receiving the Urgent-care Claim. The notice will describe the specific information necessary to complete the claim. The Claimant will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information - but not less than 48 hours.

Humana will provide notice of the plan's Urgent-care Claim determination as soon as possible but no more than 48 hours after the earlier of:

- The plan receives the specified information; or
- The end of the period afforded the Claimant to provide the specified additional information.

Concurrent-care Decisions

Humana will notify a Claimant of a Concurrent-care Decision involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination.

Humana will decide Urgent-care Claims involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a Claimant of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Post-service Claims

Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

This period may be extended an additional 15 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 30-day period, Humana will notify the affected Claimant of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the Claimant will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the Claimant responds or the expiration of the time allowed for submission of the requested information.

Initial Denial Notices

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving Urgent-care Claims, notice may be provided to Claimants orally within the time frames noted above. If oral notice is given, written notification must be provided no later than 3 days after oral notification.

A claims denial notice will convey the specific reason for the *adverse determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to Claimants, free of charge, upon request.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an Urgent-care Claim, the notice will provide a description of the plan's expedited review procedures.

APPEALS OF ADVERSE DETERMINATIONS

A Claimant must appeal an *adverse determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a Claimant by means of written application to Humana, in person, or by mail, postage prepaid.

A Claimant, on appeal, may request an expedited appeal of an adverse Urgent-care Claim decision orally or in writing. In such case, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the Claimant by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim.

On appeal, a Claimant may review relevant documents and may submit issues and comments in writing. A Claimant on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, or other service is experimental, investigational, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time Periods for Decisions on Appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

Urgent-care Claims	As soon as possible but no later than 72 hours after Humana receives the appeal request.
Pre-service Claims	Within a reasonable period but no later than 30 days after Humana receives the appeal request.
Post-service Claims	Within a reasonable period but no later than 60 days after Humana receives the appeal request.
Concurrent-care Decisions	Within the time periods specified above depending on the type of claim involved.

Appeals Denial Notices

Notice of a claim denial (including a partial denial) will be provided to Claimants by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse determination*.
- Reference to the specific plan provision upon which the determination is based.
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the Claimant, free of charge, upon request.
- A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures, and a statement about the Claimant's right to bring an action under section 502(a) of ERISA.
- If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be

provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the event an appealed claim is denied, the Claimant, will be entitled to receive without charge reasonable access to, and copies of, any documents, records or other information that:

- Was relied upon in making the determination.
- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination.
- Demonstrates compliance with the administrative processes and safeguards required in making the determination.
- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether the statement was relied on in making the benefit determination.

EXHAUSTION OF REMEDIES

Upon completion of the appeals process under this section, a Claimant will have exhausted his or her administrative remedies under the plan. If Humana fails to complete a claim determination or appeal within the time limits set forth above, the claim shall be deemed to have been denied and the Claimant may proceed to the next level in the review process.

After exhaustion of remedies, a Claimant may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

LEGAL ACTIONS AND LIMITATIONS

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

MEDICAL CHILD SUPPORT ORDERS

An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSO).

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that: (a) provides for support of a covered employee's child; (b) provides for health care coverage for that child; (c) is made under state domestic relations law (including a community property law); (d) relates to benefits under the group health plan; and (e) is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law. QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act section 1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.

CONTINUATION OF COVERAGE FOR FULL-TIME STUDENTS DURING MEDICAL LEAVE OF ABSENCE

A dependent child who is in regular full-time attendance at an accredited secondary school, college or university, or licensed technical school continues to be eligible for coverage for until the earlier of the following if the dependent child takes a medically necessary leave of absence:

- Up to one year after the first day of the medically necessary leave of absence; or
- The date coverage would otherwise terminate under the plan.

We may require written certification from the dependent child's health care practitioner that the dependent child has a serious bodily injury or sickness requiring a medically necessary leave of absence.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You are receiving this notice because you have recently become covered under a group health and/or dental plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health and/or dental coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health and/or dental coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's benefit plan document or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, the qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following events happen:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorce or legally separation from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child) you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Once the Plan Administrator offers COBRA continuation coverage, the qualified beneficiaries must elect such coverage within 60 days.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage last for up to a total of 36 months. When the qualifying event is the end of employment, or reduction in the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which the employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA

continuation coverage generally last for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of such determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is given to the Plan within 60 days of the event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, or other laws affecting your group health and/or dental plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (address and phone numbers of Regional and District EBSA Office are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send the Plan Administrator.

IMPORTANT NOTICE FOR INDIVIDUALS ENTITLED TO MEDICARE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) OPTIONS

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options.

OPTION 1 - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.

OPTION 2 - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

Category 1 Medicare eligibles are:

- Covered employees in active service who are age 65 or older who choose Option 1;
- Age 65 or older covered spouses; and
- Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;

Category 2 Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:

- Retired employees and their spouses; or
- Covered dependents of a covered employee, other than his or her spouse.

Calculation and Payment of Benefits

For covered persons in Category 1, benefits are payable by the policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an employee is granted a leave of absence (Leave) by the employer as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other employees who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Continuation of Benefits

Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

Eligibility

An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

Duration of Coverage

Of elected, continuation coverage under USERRA will continue until the earlier of:

1. Twenty-four months beginning the first day of absence from employment due to service in the uniformed services; or
2. The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

Under federal law, the period coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependent.

Other Information

Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or change of address.

YOUR RIGHTS UNDER ERISA

Under the Employee Retirement Income Security Act of 1974 (ERISA), all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

Information About the Plan and Benefits

Plan participants may:

1. Examine, free of charge, all documents governing the plan. These documents are available in the plan administrator's office.
2. Obtain, at a reasonable charge, copies of documents governing the plan, including a copy of any updated summary plan description and a copy of the latest annual report for the plan (Form 5500), if any, by writing to the plan administrator.
3. Obtain, at a reasonable charge, a copy of the latest annual report (Form 5500) for the plan, if any, by writing to the plan administrator.

As a plan participant, you will receive a summary of any material changes made in the plan within 210 days after the end of the plan year in which the changes are made unless the change is a material reduction in covered services or benefits, in which case you will receive a summary of the material reduction within 60 days after the date of its adoption.

If the plan is required to file a summary annual financial report, you will receive a copy from the plan administrator.

Responsibilities of Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plan. These people, called "fiduciaries" of the plan, have a duty to act prudently and in the interest of plan participants and beneficiaries.

No one, including an employer, may discharge or otherwise discriminate against a plan participant in any way to prevent the participant from obtaining a benefit to which the participant is otherwise entitled under the plan or from exercising ERISA rights.

Continue Group Health Plan Coverage

Participants may be eligible to continue health care coverage for themselves, their spouse or dependents if there is a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the COBRA notice in this document regarding the rules governing COBRA continuation coverage rights.

Claims Determinations

If a claim for a plan benefit is denied or disregarded, in whole or in part, participants have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance, if a participant requests a copy of plan documents does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$ 110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court. In addition, if the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court. If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with Questions

Contact the group health plan human resources department or the plan administrator with questions about the plan. Contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210 with questions about ERISA rights. Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

PRIVACY AND CONFIDENTIALITY STATEMENT

We understand the importance of keeping your personal and health information private (PHI). PHI includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. We are required by applicable federal and state law to maintain the privacy of your PHI.

Under both law and our policies, we have a responsibility to protect the privacy of your PHI. We:

- Protect your privacy by limiting who may see your PHI;
- Limit how we may use or disclose your PHI;
- Inform you of our legal duties with respect to your PHI;
- Explain our privacy policies; and
- Strictly adhere to the policies currently in effect.

We reserve the right to change our privacy practices at any time, as allowed by applicable law, rules and regulations. We reserve the right to make changes in our privacy practices for all PHI that we maintain, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will send notice to our health plan subscribers. For more information about our privacy practices, please contact us.

As a covered person, we may use and disclose your PHI, without your consent/authorization, in the following ways:

Treatment: we may disclose your PHI to a health care practitioner, a hospital or other entity which asks for it in order for you to receive medical treatment.

Payment: we may use and disclose your PHI to pay claims for covered services provided to you by health care practitioners, hospitals or other entities.

We may use and disclose your PHI to conduct other health care operations activities.

It has always been our goal to ensure the protection and integrity of your personal and health information.

Therefore, we will notify you of any potential situations where your identification would be used for reasons other than treatment, payment and health plan operations.