

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

**CERTIFICATE
GROUP EYE CARE INSURANCE**

The Policyholder **JEFFERSON COUNTY BOARD OF EDUCATION**

Policy Number **160-645818** **Insured Person**

Plan Effective Date **January 1, 2012** **Certificate Effective Date**
Refer to Exceptions on 9070.

Class Number 2

Standard Insurance Company certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

STANDARD INSURANCE COMPANY



J. Greg Ness
President

KENTUCKY
Important Information about your Benefits
Notice of Appeal Procedures

Please refer to your Explanation of Benefits to see the benefit decision for your claim or pre-treatment estimate of benefits. Any Adverse Determinations, as defined below, are made by licensed dentists as noted on your Explanation of Benefits. Coverage denials, as defined below, are made under the direction of the Vice President, Group Customer Relations and Operations.

After reading your Explanation of Benefits, you can call us with any questions. You have the right to file an appeal with us if all or part of a benefit determination resulted in denial or reduction of a benefit. The following information describes how you can appeal and how we will process your appeal.

Please read this notice carefully. This notice contains important information about how to file an appeal with us. In order to initiate an appeal, during normal business hours, please contact: **Dental Quality Assurance, PO Box 82629, Lincoln, NE 68501-2629, 888-418-6811 (Toll-Free), 402-309-2580 (facsimile)**

I. Definitions

"Adverse Determination" means a determination by us that the health care services furnished or proposed to be furnished to a covered person are:

1. Not medically necessary, or are considered experimental or investigational, as determined by us; and
2. Benefit coverage is therefore denied, reduced, or terminated.

"Adverse determination" does **not** mean a determination by us that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's limited health benefit plan.

"Authorized Person" means a parent, guardian, or other person authorized to act on behalf of a covered person with respect to health care decisions.

"Coverage Denial" means our determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's limited health benefit plan.

"Covered Person" means a person covered under our limited a health benefit plan.

"Department" means the Kentucky Department of Insurance.

"Expedited Appeal" means that either an appeal of an adverse determination or coverage denial is necessary when in the absence of immediate medical attention could result in any of the following:

1. Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or the unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of a bodily organ or part.

II. Levels of Appeals

A. Internal Appeals Process for Non-Expedited Appeals.

The internal appeals process may be initiated by the covered person, an authorized person, or a provider acting on behalf of the covered person within sixty (60) days after receipt of a notice of adverse determination or coverage denial. A provider is not required to obtain written permission from the Covered Person in order to formally request an appeal or file a grievance. We will provide review decisions to covered persons, authorized persons, and providers on internal appeals of adverse determinations or coverage denials within thirty (30) days of receipt of the request for internal appeal. The internal appeal review of an adverse determination shall only be conducted

by a licensed provider who did not participate in the initial review and denial. If the case under review requires review of a specialist, then upon request of a covered person, we shall utilize a board eligible or certified provider in the appropriate specialty area to conduct the appeal review. Those portions of the medical records that are relevant to the internal appeal, if authorized by the covered person and in accordance with state or federal law, shall be considered and providers will be given the opportunity to present additional information.

Following the internal appeal, we will provide the covered person, authorized person, or provider acting on behalf of the covered person with an internal appeal determination letter that will include:

1. A statement of the specific medical and scientific reasons for denying coverage or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;
2. The state of licensure, medical license number, and the title of the person making the decision;
3. For pre-treatment estimates, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and
4. Instructions for filing a complaint with the Department if an adverse determination is upheld by the insurer on internal appeal.

If the covered person, authorized person, or provider has new clinical information regarding the covered person's internal, he or she may provide that information to us. We will have five (5) business days from the date of the receipt of the information to render a decision based on the new information.

Following the internal appeal of a coverage denial, we will provide the Covered Person, authorized person, or provider acting on behalf of the covered person a letter that will include:

1. The date of the review decision and notification that the decision was made under the direction of the Vice President, Group Customer Relations and Operations
2. Identification of the schedule of benefits provision or exclusion that demonstrates that coverage is not available;
3. Except for retrospective reviews, a description of alternative benefits, services or supplies that the policy covers, if any; and
4. Instructions for filing a complaint with the Department if a coverage denial is upheld by the insurer on internal appeal.

B. Expedited Internal Appeals

We shall render a decision not later than three (3) business days after receipt of the request for an expedited internal appeal of either an adverse determination or a coverage denial.

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**SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE**

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class

Class Description

Class 2

Eligible Employee Electing The High Plan

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

When a Participating Provider is used:

Deductible Amount:

Exams - Each Benefit Period	\$5
Frames	\$0
Lenses - Each Benefit Period	\$5

When a Non-Participating Provider is used:

Deductible Amount	\$0
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Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

DEFINITIONS

COMPANY refers to Standard Insurance Company. The words "we", "us" and "our" refer to Company. Our Home Office address is 900 SW Fifth Avenue, Portland, Oregon 97204-1282.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

- a. who is a Member of the eligible class; and
- b. who has qualified for insurance by completing the eligibility period, if any; and
- c. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

- a. an Insured's spouse.
- b. each child less than 26 years of age, for whom the Insured or the Insured's spouse is legally responsible, or is eligible under the federal laws identified below, including:
 - i. natural born children;
 - ii. adopted children, eligible from the date of placement for adoption;
 - iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

Spouses of Dependents and children of Dependents may not be enrolled under this policy. Additionally, if the Policyholder's separate medical plans are considered to have "grandfathered status" as defined in the federal Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, Dependents may not be eligible Dependents under such medical plans if they are eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent for plan years beginning before January 1, 2014. Dependents that are ineligible under the Policyholder's separate medical plans will be ineligible under this Policy as well.

- c. each child age 26 or older who:
 - i. is Totally Disabled as defined below; and
 - ii. becomes Totally Disabled while insured as a dependent under b. above.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and
2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a member of the Eligible Class for Insurance is any eligible employee electing the high plan working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

ANNUAL ENROLLMENT SWITCH PERIOD. An Annual Enrollment Switch Period for the eye care plans will be held each December to be effective January 1 to allow members to move from one eligible eye care Class to another eligible eye care Class. However, if a member terminates from the eye care Class they have elected, they are not eligible to re-enroll within an eligible eye care Class until the next Annual Enrollment Switch Period.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or first following the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 3rd birthday. The child may be added at birth or within 31 days of the 3rd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any eligible employee electing the high plan working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

SECTION 125. This policy is provided as part of the Policyholder's Section 125 Plan. Each Member has the option under the Section 125 Plan of participating or not participating in this policy.

If a Member does not elect to participate when initially eligible, the Member may elect to participate at a subsequent Election Period. This Election Period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.

Members may change their election option only during an Election Period, except for a change in family status. Such events would be marriage, divorce, birth of a child, death of a spouse or child, or termination of employment of a spouse.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of employment. The Eligibility Period will be reduced by any continuous period during which you were an employee of the Employer immediately preceding the date you became a Member.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of employment. The Eligibility Period will be reduced by any continuous period during which you were an employee of the Employer immediately preceding the date you became a Member.

Reinstated employees: If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or first following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.
2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

EYE CARE EXPENSE BENEFITS

If an Insured has Covered Expenses under this section, we pay benefits as described. The Insured may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to choose any provider.

AMOUNT PAYABLE

The Amount Payable for Covered Expenses is the lesser of:

- A. the provider's charge, or
- B. the Maximum Covered Expense for such services or supplies. This is shown in the Schedule of Eye Care Services for Participating and Non-Participating Providers.

DEDUCTIBLE AMOUNT

The Deductible Amount is on the Schedule of Benefits. It is an amount of Covered Expenses for which no benefits are payable. It applies separately to each Insured. Benefits are paid only for those Covered Expenses that are over the Deductible Amount.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS

A Participating Provider agrees to provide services and supplies to the Insured at a discounted fee. A Non-Participating Provider is any other provider.

COVERED EXPENSES

Covered expenses are the eye care expenses incurred by an Insured for services or supplies. We pay up to the Maximum Covered Expense shown in the Schedule of Eye Care Services.

EYE CARE SUPPLIES

Eye care supplies are all services listed on the Schedule of Eye Care Services. They exclude services related to Eye Care Exams.

REQUEST FOR SERVICES

When requesting services, the Insured must advise the Participating Provider's office that he or she has coverage under this network plan. If the Insured receives services from a Participating Provider without this notification, the benefits are limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS

We pay benefits to the Participating Provider for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, we pay benefits to the Insured.

EXTENSION OF BENEFITS

We will extend benefits for eye care supplies if this policy terminates. To be eligible for an extension, the supply must be prescribed prior to the termination of the policy and must be received within six months after the policy terminates.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply item furnished.

LIMITATIONS

This plan has the following limitations.

- 1) This plan does not cover more than one Eye Exam in any 12-month period.
- 2) This plan does not cover more than one pair of ophthalmic Lenses in any 12-month period.
- 3) This plan does not cover more than one set of Frames in any 24-month period.

- 4) This plan does not cover Elective Contact Lenses more than once in any 12-month period. Contact Lenses and associated expenses are in lieu of any other Lenses benefit.
- 5) This plan does not cover Medically Necessary Contact Lenses more than once in any 12-month period. The treating provider determines if an Insured meets the coverage criteria for this benefit as listed below. This benefit is in lieu of Elective Contact Lenses.
 - a. For Keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses.
 - b. Patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best standard spectacle lens correction.
 - c. Anisometropia of 3D or more.
 - d. High Ametropia exceeding -10D or +10D in spherical equivalent.
- 6) This plan does not cover Orthoptics or vision training and any associated testing.
- 7) This plan does not cover Plano Lenses.
- 8) This plan does not cover non-prescribed Lenses or sunglasses.
- 9) This plan does not cover two pairs of glasses in lieu of Bifocals.
- 10) This plan does not cover replacement of Lenses and Frames that are lost or broken outside of the normal coverage intervals.
- 11) This plan does not cover medical or surgical treatment of the eyes or supporting structures.
- 12) This plan does not cover services for claims filed more than one year after completion of the service. An exception is if the Insured shows it was not possible to submit the proof of loss within this period.
- 13) This plan does not cover any procedure not listed on the Schedule of Eye Care Services

SCHEDULE OF EYE CARE SERVICES

This page lists the benefits payable for eye care services. No benefits are payable for a service not listed.

<i>SERVICE</i>	<i>PLAN MAXIMUM COVERED EXPENSE</i>	
	<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Eye Exam	Covered in Full	Up to \$ 40.00
<i>(All lenses are per pair)</i>		
Single Vision Lenses	Covered in Full	Up to \$ 40.00
Lined Bifocal Lenses	Covered in Full	Up to \$ 60.00
Lined Trifocal Lenses	Covered in Full	Up to \$ 80.00
Frame	Up to \$150.00	Up to \$ 65.00
Contact Lenses*		
Elective	Up to \$150.00	Up to \$105.00
Medically Necessary	Covered in Full	Up to \$210.00

*The contact lenses allowance applies to the contact lens exam and lenses.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90-day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible. For Eye Care benefits that use either the EyeMed or VSP network, please refer to the limitations section on the Eye Care Expense Benefits page.

TIME OF PAYMENT. We will pay all benefits within 30 days of when we receive due proof. We will pay interest at the rate of twelve percent (12%) per annum on benefits for valid claims from and after the 30 day period. If we do not pay benefits when due, the Insured or the Provider may bring legal action to recover benefits, interest and any other damages allowable by law, including reasonable attorneys fees incurred.

PAYMENT OF BENEFITS. All benefits will be paid to the Insured unless otherwise agreed upon through your authorization or provider contracts.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed \$5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. Eligibility and Benefits Provided Under the Group Policy

Please refer to the **Conditions for Insurance** within the Group Policy and Certificate of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

B. Qualified Medical Child Support Order ("QMCSO")

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

C. Termination Of The Group Policy

The Group Policy which provides benefits for this plan may be terminated by the Policyholder at any time with prior written notice to Standard Insurance Company. It will terminate automatically if the Policyholder fails to pay the required premium. Standard Insurance Company may terminate the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Standard Insurance Company believes the Policyholder has failed to perform its obligations relating to the Group Policy.

After the first policy year, Standard Insurance Company may also terminate the Group Policy on any Premium Due Date for any reason by providing a 30-day advance written notice to the Policyholder.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Standard Insurance Company executive officer.

D. Claims For Benefits

Claims procedures are furnished automatically, without charge, as a separate document.

E. Continuation of Coverage Provisions (COBRA)

COBRA (Consolidation Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

i. Definitions For This Section

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);
2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);
3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);

4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);
5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);
6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);
7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

ii. Electing COBRA Continuation

- A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:
 1. The date on which Insurance would otherwise end; and
 2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.
- B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:
 1. The Member's Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;
 2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and
 3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

iii. Notice Requirements

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.
2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:
 - a. The date of the Qualifying Event; or
 - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security

Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:

- a. The date of the disability determination;
 - b. The date of the Qualifying Event; or
 - c. The date on the Qualified Beneficiary loses coverage due to the Qualifying Event.
4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:
- a. The date of the Qualifying Event; or
 - b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.
5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.
6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. **COBRA Continuation For Certain Bankruptcy Proceedings**

If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. **Premium Requirements**

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. **When COBRA Continuation Ends**

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;
2. 31 days after the date the last period ends for which a required premium payment was made;
3. The last day of the COBRA continuation period.
4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;
5. The first date on which the Qualified Beneficiary is: (a) covered under another group Eye Care policy and (b) not subject to any preexisting condition limitation in that policy.

F. Your Rights under ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and

collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to operate and administer this plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you 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 you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Rights

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration.

**CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)**

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

EyeMed Vision Care
4000 Luxottica Place
Mason, Ohio 45040-8114
(866) 289-0614 phone
(513) 765-6050 fax

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
- e. A description of any additional information needed to support your claim and why such information is necessary.
- f. Information concerning your right to a review of our decision.
- g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
- d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
- e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
- f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

HIPAA Notice of Privacy Practices

To: All Insureds covered under a Eye Care Insurance policy ("Health Plan") with The Standard

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Standard Insurance Company ("The Standard") is committed to protecting the health information that we maintain about you. As required by rules effective April 14, 2003, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this notice provides you with information about your rights and our legal duties and practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures that The Standard will make of your protected health information.

"Protected health information" includes any identifiable information that we obtain from you or others that relates to your past, present or future health care and treatment or the payment for your health care and treatment. Your health care professional may have different policies or notices regarding his or her use and disclosure of your health information created in the health care professional's office or clinic.

The Standard reserves the right to change the terms of this notice and to make the revised notice effective for all protected health information we maintain. You may request a paper copy of the most current privacy notice from our office or access it on our Web site at www.standard.com/services/index.html.

Permitted Uses and Disclosures of Your Health Information

The following describes the purposes for which The Standard is permitted or required by law to use or disclose your Health Plan coverage information without your authorization:

Treatment. This means the provision, coordination or management of your health care, including any referrals for health care from one health professional to another. For example, we may use or disclose health information about you to facilitate treatment or services by health care providers. We may disclose health information about you to other health care professionals who are involved in taking care of you.

Payment. This means activities to facilitate payment for the treatment and services you receive from health care professionals, including to determine eligibility, coverage or benefit responsibilities under your insurance coverage, or to coordinate your insurance coverage. For example, the information on claim forms sent to us may include information that identifies you, as well as your diagnosis, and the procedures and supplies used. We may share this information with outside health care consultants performing a business service for The Standard. Likewise, we may share health information with other insurance carriers to coordinate benefit payments. We mail Explanation of Benefits forms and other information to the address we have on record for the primary insured. In addition, claim information may be accessible through our website and 1-800 number requiring an access code.

Health Care Operations. This means the support functions related to treatment and payment, such as quality assurance activities, case management, underwriting, premium rating, business management and other general administrative activities. For example, we may use health information in connection with conducting quality assessment and improvement activities, underwriting, premium rating and other activities relating to your coverage. We may also disclose health information to business associates if they need to receive health information to provide a service to us and by contract agree to abide by the same high standards of safeguarding your health information.

As Required by Law or for Public Health Activities. We will disclose health information about you when required to do so by federal, state or local law. For example, we may disclose health information when required by a court order, subpoena, warrant, summons or similar process. We may disclose health information to public

health or legal authorities charged with preventing or controlling communicable disease or to a governmental agency or regulator with health care oversight responsibilities.

Military and Veterans. If you are a member of the armed forces, we may disclose health information about you as required by military command authorities.

Workers' Compensation. We may disclose health information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Coroners and Medical Examiners. We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

Law Enforcement and National Security and Intelligence Activities. We may disclose health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

To Avert a Serious Threat to Health or Safety. We may disclose health information to avert a serious threat to someone's health or safety. We may disclose health information to federal, state or local agencies engaged in disaster relief to allow such entities to carry out their responsibilities in specific disaster situations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others or (3) for the safety and security of the correctional institution.

Disclosure to your Plan Sponsor. Information may be disclosed to your plan sponsor for purposes of plan administration if the plan sponsor has certified that plan documents have been amended as required by HIPAA.

Other Uses and Disclosures of Your Health Information. Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization.

Your Rights Regarding Your Health Information

The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to Standard Insurance Company, Attn: Quality Assurance Specialist, PO Box 82629, Lincoln, NE 68501-2629.

Right to Inspect and Copy. You have the right to inspect and copy health information that we maintain about you. To inspect or copy your health information, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Please contact our Privacy Contact at the address or telephone number listed on the last page of this document if you have questions about access to your health information.

Right to Amend. If you feel that the health information we have about you is incorrect or incomplete, you may ask us in writing to amend the information. You have the right to request an amendment for as long as we maintain the information.

In addition, you must provide a reason that supports your request. Any agreed-upon correction to your health information will be included as an addition to, and not a replacement of, already existing records.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the health information kept by us, (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy or (4) is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of your health information made by us in the six years prior to the date that the accounting is requested (or shorter period as requested). This does not include disclosures (1) to carry out treatment, payment, or health care operations; (2) made to you or pursuant to your authorization; (3) for national security or intelligence purposes; (4) to corrections institutions or law enforcement officials or (5) made prior to April 14, 2003.

Your first request for an accounting in any 12-month period shall be provided without charge. A reasonable fee shall be imposed for each subsequent request for an accounting within the same 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation of the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to your request.

To request restrictions, you must make your request in writing to our Privacy Contact indicated below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We will not ask you the reason for your request. Please make this request in writing to our Privacy Contact indicated below.

Your Right to File a Complaint. If you believe your privacy rights have been violated, please submit your complaint in writing to:

Standard Insurance Company
Attn: Quality Assurance Specialist
PO Box 82629
Lincoln, NE 68501-2629

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Privacy Contact

If you have any questions or would like further information about this notice or your rights regarding your health information, please contact the Quality Assurance Specialist at 800.547.9515 or the above address.

This notice is revised effective April 14, 2006.

