Group Benefits

Meade School District 46-1

Vision

CERTIFICATE OF
GROUP INSURANCE

Union Security Insurance Company certifies that the insurance stated in this Certificate became effective on the Effective Date shown below. This Certificate is subject to the provisions of the below numbered *policy* issued by Union Security Insurance Company to the *policyholder*.

Policyholder: Meade School District 46-1

Group Policy Number: 5482818

Effective Date: For vision expenses incurred on or after January 1, 2017

Type of Insurance: Group Vision Insurance
Group Vision Insurance for Dependents

This Certificate replaces any and all Certificates and Certificate Endorsements, if any, issued to you under the *policy*.

President and
Chief Executive Officer

Group Claim and Grievance Notice

If you have any questions regarding filing a claim, understanding how a determination was made or need assistance in filing a grievance, please contact our customer service department by telephone at 800.733.7879.

You also have the right to contact the South Dakota Division of Insurance at any time for assistance on all matters concerning your insurance with us. The department may be contacted at:

South Dakota Division of Insurance
124 South Euclid Avenue, 2nd Floor
Pierre, South Dakota 57501-2000
www.state.sd.us/insurance
Telephone: 605.773.3563
Fax: 603.773.5369

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent or Union Security, please have your policy or participation number available.

SCHEDULE

Eligible Class: For employee insurance - Each *full-time* employee of the *policyholder* or an *associated company*,

- who is at *active work*, and
- who is working in the United States of America,

as identified on the *policyholder's* or our records, except any temporary or seasonal worker.

For dependent insurance - Each *eligible dependent* of a person eligible and insured for employee insurance.

Associated Companies: None

Present Service Requirement: None

Future Service Requirement: None

Entry Date: An eligible person will become insured on the first of the month occurring on or after the day all eligibility requirements are met.

SCHEDULE (continued)

VISION INSURANCE

NETWORK PLAN

Materials:	
Well Vision Examination Available one time each *benefit period*.	**Your Cost** No Cost after $10 *co-payment*
Contact Lenses *Visually necessary** Available one time each *benefit period.*	**Your Cost** *Visually necessary* contact lenses are covered in full when specific benefit criteria are satisfied and when prescribed by a *network provider* (includes professional fees and *materials*). $25 *co-payment* applies
Elective (not *visually necessary*)** Available one time each *benefit period*, in place of glasses (lenses and frames).	15% off elective contact lens services (fitting & evaluation), excluding charges for *materials*. A $130 *allowance* is applied toward the *materials* and discounted elective contact lens services (fitting & evaluation).
Frames*** Any frame available at a *network provider* location. Available one time each *benefit period*.	**Your Cost** $25 *co-payment* (for lenses & frame) Covered in full up to the $130 *allowance* with a 20% *discount* on any amount exceeding *allowance*.
Lenses*** Available one time each *benefit period*. Coverage includes prescription glass or plastic, single vision, lined bifocal, lined trifocal or lenticular lenses. Lens options are available at cost controlled pricing as described in the Limitations and General Exclusions section.	**Your Cost (*co-payment*)** No Cost after $25 *co-payment* (lenses & frame)
Additional Pairs of Glasses (lenses and frames)	30% off additional pairs of prescription and non-prescription glasses and sunglasses, including lens options, from the same *network provider* on the same day as the covered eye exam. Also, 20% off additional pairs of prescription and non-prescription glasses and sunglasses from any *network provider* within 12 months of the covered eye exam.
Laser Surgery Available one time per eye per lifetime. Includes *discounts* towards laser surgery, photorefractive keratectomy (PRK), laser-assisted in-situ keratomileusis (LASIK), custom LASIK and education *materials*.	**Your Cost (*discount* off *network providers* normal charge)** *Discounts* averaging 15% off the *network providers* normal charge for laser surgery or 5% off any promotional price.****

**Visually necessary* contact lenses are a plan benefit when specific benefit criteria are satisfied and when prescribed by a *network provider* or *out-of-network provider*. Prior review and approval by *network plan* manager are not required to be eligible for *visually necessary* contact lenses.

Visually necessary contact lenses or elective contact lenses are provided in lieu of all other lens and frame benefits described in the Schedule.

***Network providers* will provide 15% *discount* to their normal professional fees for the evaluation and fitting of elective contact lenses.

SCHEDULE (continued)

***Benefits for lenses are per complete set, not per lens.

Benefits for lenses and frames include reimbursement for the following *visually necessary* professional services:
1. Prescribing and ordering proper lenses;
2. Assisting in frame selection;
3. Verifying accuracy of finished lenses;
4. Proper fitting and adjustments of frames;
5. Subsequent adjustments to frames to maintain comfort and efficiency;
6. Progress or follow-up work as necessary.

Frame allowance may be applied towards non-prescription sunglasses for post PRK, LASIK, or custom LASIK patients.

**** If the *network provider* is offering a price reduction for laser surgery, you or your *covered dependent* will receive an additional 5% off the promotional price. Check with the *network provider* for specific *discounts* available.

OUT-OF-NETWORK PLAN

Examination Available one time each *benefit period*.	**Allowance** Reimbursed up to $52 *allowance*.
Materials:	
Contact Lenses (includes fit, follow-up, professional services and *materials*) Available one time each *benefit period*.	**Allowance**
Visually necessary Available one time each *benefit period*.	Reimbursed up to the $210 *allowance*.
Elective (not *visually necessary*) Available one time each *benefit period*.	Reimbursed up to the $105 *allowance*.
Frames	**Allowance**
Any frame available at *provider* location Available one time each *benefit period*.	Reimbursed up to the $57 *allowance*.
Lenses Available one time each *benefit period*.	**Allowance**
Single Vision	Reimbursed up to the $55 *allowance*.
Lined Bifocal	Reimbursed up to the $75 *allowance*.
Lined Trifocal	Reimbursed up to the $95 *allowance*.
Lenticular	Reimbursed up to the $125 *allowance*.

BENEFIT PERIODS (IN NETWORK AND OUT-OF-NETWORK PLANS)

Examination	12 Months
Frames	24 Months
Lenses or Contact Lenses	12 Months

NOTE:
Discounts do not apply for benefits provided by *other group vision expense coverage*.

Each *allowance* shown above can be applied only one time during a *benefit period*. There is no remaining balance available for the current *benefit period* or to carry over to the next *benefit period*.

ADDITIONAL DISCOUNTS

You and each *covered dependent* shall be entitled to receive a *discount* of 30% toward the purchase of additional complete pairs of prescription and non-prescription glasses (lenses, lens options and frames) from a *network provider* on the same day as your covered eye *examination*. You and each *covered dependent* shall be entitled to receive a *discount* of 20% toward the purchase of additional complete pairs of prescription and non-prescription glasses (lenses, lens options, and frames) from a *network provider* within 12 months of the last covered eye *examination*. Additional pair means any complete pair of prescription and non-prescription glasses purchased beyond the benefit frequency allowed under this *policy*.

Additionally, you and your *covered dependents* shall be entitled to receive a *discount* of 15% off *network provider* professional fees for elective contact lens evaluations and fittings. *Discounts* are applied to the *network providers* normal fees for such services and are available within 12 months of the covered eye *examination* from any *network provider*. Contact lens materials are provided at the *network providers* normal charges. Additional *discounts* noted on this Schedule are subject to change as deemed appropriate by the *network provider* with prior notification to *policyholder*.

NOTE: *Discounts* do not apply to vision care benefits obtained from *out-of-network providers*.

LOW VISION BENEFIT

The Low Vision Benefit is a plan benefit when specific criteria are satisfied and when prescribed by your or your *covered dependent's network provider* or *out-of-network provider*.

	Network Provider Benefit	Out-of-Network Provider Benefit
Supplementary Testing	Covered in Full	*Allowance* up to $125

Complete low vision analysis/diagnosis, which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

	Network Provider Benefit	Out-of-Network Provider Benefit
Supplemental Care Aids	75% of Cost	75% of Cost

Subsequent low vision aids as *visually necessary* or appropriate.
Co-payment for Supplemental Aids: 25% payable by you or your *covered dependent*.

The maximum benefit available for supplemental care aids is $1,000 (excluding *co-payment*) in any 24-month period.

Out-of-Network Provider Low Vision Benefit

Except for supplementary testing as noted above, low vision benefits secured from an *out-of-network provider* are subject to the same time limits and *co-payment* arrangements as described above for a *network provider*. You or your *covered dependent* should pay the *out-of-network provider* his full fee. You or your *covered dependent* will be reimbursed in accordance with an amount not to exceed what *network plan* would pay a *network provider* in similar circumstances.

NOTE: There is no assurance that this amount will be within the 25% *co-payment* feature.

Plan Changes

Plan Changes at Annual Enrollment

You may choose to change your plan of insurance from September 1 through October 31 of each year, the annual enrollment period agreed upon by the *policyholder* and us.

The effective date of a change made during the annual enrollment period will be the policy anniversary. Please see Exception to Effective Date if you are not at *active work* on the day the change in insurance would otherwise take effect, or if that day is not a regular work day. Please see Exception to Dependent Effective Date if your *covered dependent* is in a hospital or similar facility on the day the change in insurance would otherwise take effect.

Change in Family Status

You may apply for insurance or change your plan of insurance, within 31 days of a change in family status. A "change in family status" means your marriage or divorce, the death of your spouse or child, the birth or adoption of your child, or the termination of employment of your spouse, or any other event specified in the *policyholder's* IRC Section 125 plan.

If you are first applying for insurance for yourself or for your *eligible dependent* within 31 days after a change in family status, insurance will take effect on the first of the month occurring on or after the date of the request.

If you are changing your existing plan of insurance, the effective date of any change due to a change in family status will be the first of the month occurring on or after the date of the request.

Please see Exception to Effective Date if an eligible person is not at *active work* on the day insurance, or a change in insurance, would otherwise take effect, or if that day is not a regular work day. Please see Exception to Dependent Effective Date if an *eligible dependent* is in a hospital or similar facility on the day insurance, or a change in insurance, would otherwise take effect.

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GENERAL DEFINITIONS

These terms have the meanings shown here when *italicized*. The pronouns “we”, “us”, “our”, “you”, and “your” are not *italicized*.

Active work means the expenditure of time and energy for the *policyholder* or an *associated company* at your usual place of business on a *full-time* basis.

Associated company means any company shown in the *policy* which is owned by or affiliated with the *policyholder*.

Contributory means you pay part or all of the premium.

Covered dependent means an *eligible dependent* who is insured under the *policy*.

Covered person means an eligible employee of the *policyholder* or *associated company* who has become insured for a coverage.

Doctor means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. Also, a person whom we are required to recognize as a *doctor* by the laws or regulations of the governing jurisdiction, or a person who is legally licensed to practice psychiatry, psychology or psychotherapy and whose primary work activities involve the care of patients, is a *doctor*. However, neither you nor a *family member* will be considered a *doctor*.

Eligible class means a class of persons eligible for insurance under the *policy*. This class is based on employment.

Family member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent or grandchild of the *covered person*.

Full-time means working at least 20 hours per week, unless indicated otherwise in the *policy*.

Home office means our office in Kansas City, Missouri.

Noncontributory means the *policyholder* pays the premium.

Policy means the group policy issued by us to the *policyholder* that describes the benefits for which you may be eligible.

Policyholder means the entity to whom the *policy* is issued.

We, us, and our mean Union Security Insurance Company.

You and your mean an eligible employee of the *policyholder* or *associated company* who has become insured for a coverage.

DEFINITIONS FOR VISION INSURANCE

Allowance means the dollar amount provided under the plan, as shown in the Schedule. Under the *network plan*, you or your *covered dependent* must pay any amount over the *allowance*. Under the *out-of-network plan*, you or your *covered dependent* must pay the entire amount, after which the *allowance* will be reimbursed as described in the Filing a Claim section of the Claim Provisions.

Benefit authorization means authorization from the *network plan* identifying you as a *covered person* or your dependent as a *covered dependent* under the *vision insurance policy* and identifying the benefits for which you or your *covered dependent* are eligible.

Benefit period means the number of consecutive months shown in the Schedule, during which benefits are payable under the *policy*. A *benefit period* begins on the later of the date you become insured under the *policy* or the last date you incurred covered vision expenses. There may be separate *benefit periods* for an *examination* and for *materials*.

Co-payment means any dollar amount shown in the Schedule, which is required to be paid by you or your *covered dependent* at the time services are rendered or *materials* are provided. A separate *co-payment* will be applied to each covered vision expense during a *benefit period*.

Discount means any percentage off professional services or *materials* shown in the Schedule, which are required to be paid by you or your *covered dependent*. A separate *discount* may be applied to each covered vision expense during a *benefit period*.

Examination means a vision test, including a determination as to the need and method for correction of *visual acuity* that is performed by a *provider*. An *examination* may include but not be limited to the following procedures:

- case history, including
  - chief complaint or reason for visit,
  - patient medical/eye health history, and
  - record of current medications;
- record of *visual acuity* with and without present correction, if applicable;
- dilation, if necessary;
- pupil responses;
- external exam findings;
- internal exam findings;
- screening of visual fields perception;
- appraise present prescription;
- retinoscopy (when applicable);
- subjective refraction at far and near point;
- binocular and ocular mobility testing;
- test of accommodation or near point refraction;
- tonometry;
- diagnosis/prognosis; and

- specific recommendations.

Experimental nature means a procedure or lens that is not used universally or accepted by the vision care profession.

Materials means:

- low vision aids (only if the Low Vision Benefit is listed in the Schedule);
- corrective, prescription or contact lenses; or
- frames.

Multifocal lenses means lenses with more than one optical center (i.e., a bifocal, a trifocal, or *progressive lenses*).

Network provider means an *ophthalmologist*, *optician*, *optometrist*, vision center or any vision-care *provider* who is a participant in our *network plan*.

Network plan means the vision-care delivery system established by the *network plan* manager in which *network providers* participate and under which we provide certain vision benefits.

Ophthalmologist means a *doctor* specializing in the eye who is trained to examine, diagnose, treat and manage diseases of the visual system, including all types of surgical procedures.

Optician means a professional trained to fit and adjust eyewear based on the specifications provided by an *optometrist* or *ophthalmologist*.

Optometrist means a primary health care professional who can diagnose, manage and treat conditions and diseases of the human eye and visual system, as required by state law.

Orthoptics means the teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.

Other group vision expense coverage means:

- any other group policy providing benefits for vision expenses; or
- any plan providing vision expense benefits (whether through a vision services organization or other party providing prepaid health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

Out-of-network plan means the plan under which we provide certain vision benefits for services and materials received from an *out-of-network provider*.

Out-of-network provider means an *ophthalmologist*, *optician*, *optometrist*, vision center or any vision-care *provider* who is not a participant in our *network plan* at the time covered vision services are provided.

Plano lenses means lenses which have less than a +/- .50 diopter power.

Progressive lenses means *multifocal lenses* with no visible lines.

Provider means a qualified *ophthalmologist* or *optometrist* who is operating within the scope of his or her license or a dispensing *optician*.

Vision insurance means the group vision insurance under the *policy* issued by us to the *policyholder*.

Visual acuity means the sharpness of vision, the ability of the eye to distinguish detail.

Visually necessary means an *examination* and *materials* necessary to restore or maintain *visual acuity* and health.

SUMMARY OF GROUP VISION INSURANCE

This summary is intended to help understand your group insurance. It does not change any of its provisions.

Vision Insurance

The *policy* provides benefits for you or a *covered dependent* for covered vision expenses subject to any *co-payment*, *discount* or *allowance* shown in the Schedule. Any *co-payment*, *discount* or *allowance* may vary according to the *examination* performed and *materials* purchased. The *policy* explains which vision expenses receive limited or no benefits and which may be subject to the *benefit periods* shown in the Schedule.

If you or a *covered dependent* have more than one vision expense plan with us, benefits under the *policy* may be coordinated so that all benefits received are not more than the actual expenses.

In the following pages, the provisions that describe a particular coverage were designed to be used in both the *policy* and the certificate. Therefore the terms “you” and “your” are used to refer to the *covered person*.

**Please read
your certificate
carefully.**

ELIGIBILITY AND TERMINATION PROVISIONS FOR VISION INSURANCE

Eligible Persons

To be eligible for insurance, a person must:

- be a member of an *eligible class*; and
- complete any Service Requirement shown in the Schedule by continuous service with the employer, the *policyholder*, or an *associated company*.

The Present Service Requirement applies to persons in an *eligible class* on the Effective Date of the *policy*. The Future Service Requirement applies to persons who become members of an *eligible class* after that.

Effective Date for an Eligible Person

Any *noncontributory* insurance will take effect on the Entry Date shown in the Schedule in the *policy*.

For any *contributory* insurance, a person must apply for insurance on a form acceptable to us, and agree to pay part or all of the premium.

- If a person applies before becoming eligible, insurance will take effect on the Entry Date shown in the Schedule in the *policy*.
- If the application is made on the date the person becomes eligible, or within 31 days after that, insurance will take effect on the Entry Date occurring on or after the date of the application.
- If application is made more than 31 days after the day the person becomes eligible, or after insurance ended because the premium was not paid, then application must be made during an annual enrollment period. Insurance will then take effect on the policy anniversary occurring on or after the date of the application.

In no event will a person's insurance take effect before the *policyholder's* effective date.

Exception to Effective Date

If an eligible person is not at *active work* on the day insurance would otherwise take effect, insurance will not take effect until the person returns to *active work*. If the day insurance would normally take effect is not a regular work day for a person, insurance will take effect on that day if the person is able to do his or her regular job.

When a Person's Insurance Ends

A *covered person's* insurance will end on the earliest of:

- the day the *policy* ends;
- the day the *policy* is changed to end the insurance for a person's *eligible class*;
- the last day of the month in which a person is no longer in an *eligible class*;
- the last day of the month in which you stop *active work*; however, if you renew your contract with the *policyholder* for the next school year, the *policyholder* may consider insurance to continue even though you stop *active work* during the summer recess; or
- the day a required contribution was not paid.

Continuance of Insurance

If a person is unable to perform *active work* for a reason shown below, the *policyholder* may continue the person's insurance and the person's dependent insurance, if any, on a premium-paying basis provided the person remains in other respects a member of the *eligible class*. The continuance cannot be more than the maximum continuance shown below. Continuance must be based on a uniform policy, and not individual selection.

The maximum continuance for *vision insurance* is the longest applicable period described below:

- 12 months* for injury, sickness, or pregnancy;
- 3 months* for lay-off, leave of absence (other than a family or medical leave of absence described below), or change to part-time; or
- the end of the period the *policyholder* is required to allow* for a family or medical leave of absence under:
  - the federal Family and Medical Leave Act; or
  - any similar state law.

* after the last day of *active work*.

Any leave of absence, including a family or medical leave of absence described above, must be approved in advance in writing by the *policyholder* if the person's insurance is to be continued.

Reinstatement

If a person re-enters an Eligible Class within 12 months after insurance ends, the person will not have to complete the Service Requirement again. All other provisions of the *policy* will apply as if the person were newly eligible.

DEPENDENT ELIGIBILITY AND TERMINATION PROVISIONS FOR VISION INSURANCE

Eligible Dependents

Your *eligible dependents* are:

- your lawful spouse, and
- your children who are less than age 26.

“Children” include any adopted children. A child will be considered adopted on the date of placement in your home. Stepchildren and foster children are also included if they depend on you for support and maintenance. “Children” also include any children for whom you are the legal guardian, who reside with you on a permanent basis and depend on you for support and maintenance.

An *eligible dependent* will not include any person who is a member of an *eligible class*. If you and your spouse are both members of an *eligible class*, one of you may request to be an *eligible dependent* of the other. An *eligible dependent* may not be covered by more than 1 *covered person*.

Dependent Effective Date

Any *noncontributory* dependent insurance will take effect on the day the dependent becomes an *eligible dependent*, or, if later, on the Entry Date shown in the Schedule in the *policy*.

For any *contributory* dependent insurance, you must apply for dependent insurance on a form acceptable to us. You must also agree to pay your share of the premium.

- If you apply before the dependent becomes eligible, dependent insurance will take effect on the Entry Date shown in the Schedule in the *policy*.
- If you apply on the date the dependent becomes eligible, or within 31 days after that, dependent insurance will take effect on the Entry Date occurring on or after the date of your application.
- If you apply more than 31 days after the date the dependent becomes eligible or after dependent insurance ended because the premium was not paid, then application must be made during an annual enrollment period. Dependent insurance will take effect on the policy anniversary occurring on or after the date of application.

Exception to Dependent Effective Date

Dependent insurance will not take effect until your insurance for the same coverage under the *policy* takes effect.

If an *eligible dependent* is in a hospital or similar facility on the day insurance would otherwise take effect, it will not take effect until the day after the *eligible dependent* leaves the hospital or similar facility. This exception does not apply to a child born while dependent insurance is in effect. Dependent insurance for a newborn dependent child, including an adopted newborn dependent child, will automatically take effect at birth. Insurance will continue for 31 days. If you want insurance to continue for a newborn beyond 31 days, you must notify us (if you do not already have dependent child insurance) and make the required premium payment within the 31-day period.

When Dependent Insurance Ends

A dependent's insurance will end on the earliest of:

- the day the *policy* ends;
- the day the *policy* is changed to end dependent insurance;
- the last day of the month in which that dependent is no longer eligible;

- the day your insurance for the same coverage under the *policy* ends; or
- the day a required contribution for dependent insurance was not paid.

SPECIAL DEPENDENT INSURANCE CONTINUANCE PROVISIONS

As specified below, dependent *vision insurance* may continue, subject to the provisions that describe when insurance ends, and all other terms and conditions of the *policy*. Premiums are required for any coverage continued.

Physically or Mentally Handicapped Dependent Children

Dependent *vision insurance* for an *eligible dependent* child will continue beyond the date a child attains an age limit, if, on that date, he or she:

- is unable to earn a living because of physical or mental handicap; and
- is chiefly dependent upon you for support and maintenance.

We must receive proof of the above within 120 days after the child attains the age limit and each year after that, beginning 2 years after the child attains the age limit. There will be no increase in premium for this continued coverage.

Dependent *vision insurance* will end when the child is able to earn a living or is no longer dependent on you for support and maintenance.

SPECIAL FEDERAL CONTINUANCE PROVISIONS

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your *covered dependents* may have the right to continue *vision insurance* coverage beyond the date insurance would otherwise terminate. You should contact the *policyholder* concerning your right to continue coverage.

VISION INSURANCE

Insurance Provided

We will provide benefits for covered vision expenses when incurred by you or a *covered dependent* while insured under the *policy*, subject to all the terms and conditions of the *policy*. Benefits will be payable after you or a *covered dependent* have paid any *co-payment* required during the *benefit period*. Benefits for certain covered vision expenses may be provided in the form of an *allowance* or *discount.*

The amount of any *co-payment*, *allowance* or *discount* shown in the Schedule will apply to you and each *covered dependent* separately and can be applied only one time during a *benefit period*.

We will provide the benefits of the *network plan* shown in the Schedule for covered vision expenses incurred by you or a *covered dependent* if the *examination* is provided by or *materials* are purchased from a *network provider*.

Benefit authorization must be obtained prior to you or a *covered dependent* obtaining benefits for covered vision expenses from a *network provider*. When you or a *covered dependent* seek benefits from a *network provider*, you or the *covered dependent* must schedule an appointment and identify yourself as a member of the *network plan*, so the *network provider* can obtain a *benefit authorization* from the *network plan* manager. The *network plan* manager shall provide a *benefit authorization* to the *network provider* to authorize the provision of plan benefits to you or your *covered dependent*. Each *benefit authorization* will contain an expiration date, stating a specific time period for you or your *covered dependent* to obtain plan benefits.

The *network plan* manager shall issue *benefit authorizations* in accordance with the latest eligibility information furnished by the *policyholder* and you or your *covered dependent* regarding past service utilization, if any. Any *benefit authorization* issued by the *network plan* manager shall constitute a certification to the *network provider* that payment will be made, irrespective of a later loss of eligibility of you or your *covered dependent*, provided plan benefits are received prior to the *benefit authorization* expiration date.

We will provide the benefits of the *out-of-network plan* shown in the Schedule for covered vision expenses incurred by you or a *covered dependent* if the *examination* is provided by or *materials* are purchased from an *out-of-network provider*.

Covered Vision Expenses

Covered vision expenses include expenses for *examinations* and *material*s shown in the Schedule. You and each *covered dependent* are eligible for one *examination(s)* in each *benefit period*.

If the *examination* covered by this *policy* indicates that corrective *materials* are necessary for your or a *covered dependent's* visual health and welfare, benefits will be available for:

- Lenses – Up to two lenses provided one time in each *benefit period*, as shown in the Schedule.
- Frames – One frame(s) provided one time in each *benefit period*, as shown in the Schedule.
- Contact Lenses – Up to two contact lenses provided instead of regular lenses and frame, one time in each *benefit period*, as shown in the Schedule.

Services related to *examinations* and *materials* include but are not limited to:

- Prescribing and ordering proper lenses;
- Assisting in the selection of a frame;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of the frame or lenses;
- Subsequent adjustments to frames to maintain comfort and efficiency; and

- Progress or follow-up work as necessary.

Maximum *benefit periods*, *co-payments*, *discounts, allowances,* and other limits for certain services are shown in the Schedule and under the Limitations and General Exclusions provisions. Services performed outside these limits are not covered vision expenses and are your responsibility. Benefits, *co-payments, discounts* and *allowances* may differ based on whether you or a *covered dependent* use a *network provider* or an *out-of-network provider*.

Limitations

In no event will coverage exceed the lesser of:

- the actual cost of the *examination* or *materials*, or
- the limits of coverage shown in the Schedule.

The *allowance* for lenses shown in the Schedule is for two lenses. If only one lens is needed, coverage will be 50% of the *allowance* shown for two lenses.

Benefits will not be payable for replacement of lost or broken *materials* until the next eligible *benefit period*.

The *policy* is designed to cover *visually necessary* materials rather than cosmetic materials. When you or a *covered dependent* select any of the following extras, the *policy* will pay the basic cost of the allowed lenses, and you or the *covered dependent* will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- *Progressive multifocal lenses*.
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care. (Low vision care is provided only if the Low Vision Benefit is listed in the Schedule.)
- A frame that costs more than the plan *allowance*.
- Contact lenses (except as noted in the Schedule).

General Exclusions

Covered vision expenses do not include, and we will not pay benefits for, the following:

- *Orthoptic* or vision training and any associated supplemental testing.
- *Plano lenses*.
- Two or more pairs of glasses (lenses and frames), in lieu of bifocals or trifocals.
- Medical or surgical treatment of the eye, eyes, or supporting structures, except for laser surgery as shown under the Schedule.
- *Materials*, services or options not shown in the Schedule.
- Treatment or *materials* of an *experimental nature*.

Coordination of Benefits

We will consider ourselves primary and benefits under this *policy* will be determined first when you or a *covered dependent* are:

- insured under this *policy* and
- covered under another vision plan.

However, if you or a *covered dependent* are covered under two group vision policies with us, the policy under which the person is the employee will be considered primary.

When a *covered dependent* is a dependent child who is not covered as an employee, the benefits of the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the benefits of the plan that covered the parent for a longer period is primary.

If this *policy* is not considered primary, benefits under the *policy* may be reduced so that all benefits received are not more than the actual expenses.

CLAIM PROVISIONS FOR VISION INSURANCE

Payment of Benefits

We will pay benefits when we receive all the required proof of covered loss.

To Whom Payable

If you receive services from a *network provider*, we will pay benefits for covered vision expenses directly to the *provider* of an *examination* or *materials*. If you receive services from an *out-of-network provider*, we will reimburse you for covered vision expenses payable under the *policy* which have been paid by you. After your death, we have the option to pay any benefits due to your spouse, to the *provider*, or to your estate.

Filing a Claim

If you select a *network provider*, at the time the *provider* performs the *examination* or provides *materials*, pay your *co-payment* and any other charges not covered at the time of service. No paperwork is required.

If you select an *out-of-network provider*, you do not receive the preferred pricing available through a *network provider*. You must provide full payment to the *out-of-network provider* at the time of service. You must submit the original invoice including an itemized statement of charges and your prescription to the address obtained by calling toll-free 800.877.7195.

We must have written notice of any covered service within 180 days after it occurs. You can send the notice to the address obtained by calling toll-free 800.877.7195. We need enough information to identify you or your dependent as a *covered person* or *covered dependent*. Failure to submit a claim within this time period, however, shall not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time period, provided the claim was submitted as soon as reasonably possible and in no event, except in absence of legal capacity, later than one year from the required date of 180 days after the date of service.

We will ask you to authorize the sources of vision services to release your medical information. If you do not furnish any required information or authorize its release, we will not reimburse you for benefits.

If it is not reasonably possible to give proof on time, we will not deny or reduce your claim if you give us proof as soon as reasonably possible.

Complaints and Grievances

You shall report any complaints and/or grievances to us or the *network plan* manager at the address obtained by calling toll-free 800.877.7195. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to us verbally or in writing. You may submit written comments or supporting documentation concerning your complaint or grievance to assist in our review. We will resolve the complaint or grievance within 30 days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than 120 days after our receipt of the complaint or grievance. If we determine that resolution cannot be achieved within 30 days, we will notify you of the expected resolution date. Upon final resolution, we will notify you of the outcome in writing.

Claim Denial Appeals

If, under the terms of this *policy*, a claim is denied in whole or in part, a request may be submitted to us by you, or your authorized representative, for a full review of the denial. You may designate any person, including your *provider*, as your authorized representative. References in this section to “you” include your authorized representative, where applicable.

Initial Appeal

The request must be made within 180 days following denial of a claim and should contain sufficient information to identify the person for whom the claim was denied, including:

- your or your *covered dependent’s* name;
- your or your *covered dependent’s* identification number and date of birth;
- the provider of services; and
- the claim number.

You or your *covered dependent* may review, during normal working hours, any documents held by us pertinent to the denial. You or your *covered dependent* may also submit written comments or supporting documentation concerning the claim to assist in our review. Our response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to you or your *covered dependent* as follows:

Denied Claims for Services Rendered: within 30 calendar days after receipt of a request for an appeal from you or your *covered dependent*.

Second Level Appeal

If you disagree with the response to the initial appeal of the claim, you have a right to a second level appeal. Within 60 calendar days after receipt of our response to the initial appeal, you may submit a second appeal to us along with any pertinent documentation. We shall communicate our final determination to you in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies

When you have completed the appeals process described above, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. The *policyholder* should advise you to contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a)(1)(B)) 29 U.S.C. 1132(a)(1)(B), you have the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and you disagree with the outcome.

Limit on Legal Action

No action at law or in equity may be brought against the *policy* until at least 60 days after you file proof of loss. No action can be brought after the statute of limitations in your state has expired, but, in any case, not after 3 years from the date of loss.

Incontestability

The validity of the *policy* cannot be contested after it has been in force for 2 years, except if premiums are not paid.

In the absence of fraud, any statement made by the *policyholder*, a *covered person* or a *covered dependent* will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the *covered person* or a *covered dependent.*

No statement, except fraudulent misstatement, made by a *covered person* or a *covered dependent* about insurability will be used to deny a claim for a loss incurred after coverage has been in effect for 2 years.

No claim for loss starting 2 or more years after the *covered person's* or *covered dependent's* effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

Overpayment

If a benefit is paid under the *policy* and it is later shown that a lesser amount should have been paid, we will be entitled to a refund of the excess amount from the *provider* or you.

GENERAL PROVISIONS

Entire Contract

The *policy* and the *policyholder's* application attached to it are the entire contract. Any statement made by you or the *policyholder* is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary, but not beyond 3 years before the date the error was found. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about a person or the *policyholder's* plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Certificates

We will send certificates to the *policyholder* to give to each *covered person*. The certificate will state the insurance to which the person is entitled. It does not change the provisions of the *policy*.

Workers' Compensation

The *policy* is not in place of, and does not affect any state's requirements for coverage by Workers' Compensation insurance.

Agency

Neither the *policyholder*, any employer, any *associated company*, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the *policy* and recovery of any amounts we have paid.

HIPAA Notice of Privacy Practices

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

This Notice applies to our HIPAA covered healthcare plans, including dental, vision, cancer only, hospital indemnity, and critical illness.

I. Our Commitment

Union Security Insurance Company, Union Security Life Insurance Company of New York, and the prepaid dental companies* are committed to protecting the personal information entrusted to us by our customers. The trust you place in us when you share your personal information is a responsibility we take very seriously and is the cornerstone of how we conduct our business.

The Health Insurance Portability and Accountability Act (HIPAA) provides guidelines and standards to follow when we use or disclose your Protected Health Information (PHI). This law also gives you, our customer, numerous rights regarding your ability to see, inspect, and copy your PHI. Because our commitment to privacy means complying with all privacy laws, we are providing you this notice outlining our privacy practices. The following information is intended to help you understand what we can and cannot do with your PHI and what your rights are under HIPAA.

II. Our Use and Disclosure of Your PHI

HIPAA allows us to use and disclose your PHI for treatment, payment, and healthcare operations without asking your permission. For instance, we may disclose information to a healthcare provider to assist the provider in properly treating you or a dependent (Treatment). We may disclose certain information to the healthcare provider in order to properly pay a claim or to your employer in order to collect the correct premium amount (Payment). We may disclose your information in order to help us make the correct underwriting decision or to determine your eligibility (Operations).

Other examples of possible disclosures for purposes of healthcare operations include:

- Underwriting our risk and determining rates and premiums for your healthcare plan;
- Determining your eligibility for benefits;
- Reviewing the competence and qualifications of healthcare providers;
- Conducting or arranging for review, legal services, and auditing functions, including fraud and abuse detection and compliance;
- Business planning and development;
- Business management and general administrative duties such as cost-management, customer service, and resolution of internal grievances;
- Other administrative purposes.

We can also make disclosures under the following circumstances without your permission:

- As required by law, including response to court and administrative orders, or to report information about suspected criminal activity;
- To report abuse, neglect, or domestic violence;
- To authorities that monitor our compliance with these privacy requirements;
- To coroners, medical examiners, and funeral directors;
- For research and public health activities, such as disease and vital statistic reporting;

- To avert a serious threat to health or safety;
- To the military, certain federal officials for national security activities, and to correctional institutions;
- To the entity sponsoring your group healthcare plan but only for purposes of enrollment, disenrollment, eligibility or for the purpose of giving the plan sponsor summary information when necessary to help make decisions regarding changes to the plan. If the plan sponsor has certified that its plan documents have been amended to include certain privacy provisions, we may also disclose protected health information to the plan sponsor to carry out plan administration functions that the plan sponsor performs on behalf of the plan;
- To a spouse, family member, or other personal representative if they can show they are assisting in your care or payment of your care and then, without an authorization, only basic information about the status or payment of a claim.

Unless you give us written authorization, we cannot use or disclose your PHI for any reason except as otherwise described in this notice, including uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, and disclosures that constitute the sale of protected health information. We are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes. You may revoke your written authorization at any time by writing us at the address indicated at the end of this notice.

III. Your Individual Rights

You have the following rights with regard to your Protected Health Information:

- **To Restrict our Use or Disclosure.** You have the right to ask us to limit our use or disclosure of your PHI. While we will consider your request, we are not legally required to agree to the additional restrictions. If we do agree to all or part of your request, we will inform you in writing. We cannot agree to limit any use and disclosure of your PHI if the use or disclosure is required by law.
- **To Access your PHI.** You have the right to view and/or copy your PHI at any time by contacting us. If you want copies of your PHI, or want your PHI in a special format, we may charge you a fee. You have a right to choose what portions of your PHI you want copied and to have prior notice of copying costs. If for some reason we deny your request for access to your PHI, we will provide a written explanation of why your request was denied and explain how you can appeal the denial.
- **To Amend your PHI.** You have the right to amend your PHI, if you believe it is incomplete or inaccurate. Your request must be in writing, with an explanation of why you feel the information should be amended. If we approve your request to amend your PHI, we will make reasonable efforts to inform others, including people you name, about the amendment to your PHI. We may deny your request for various reasons, for example, if we determine that the information is correct and complete, or if we did not create the information. If we deny your request, we will provide you a written explanation of our decision. We also will explain your rights regarding having your request and our response included with all future disclosures of your PHI.
- **To Obtain an Accounting of our Disclosures.** You have the right to receive a listing from us of all instances in the past six years in which we or our business associates have disclosed your PHI for purposes <u>other</u> than treatment, payment, health care operations, or as authorized by you. The accounting will tell you the date we made the disclosure, the name of the person or entity to whom the disclosure was made, a description of the PHI that was disclosed, and the reason for the disclosure. There may be a charge for accounting disclosures if requested more than once a year.
- **To Request Alternative Communications.** You have the right to ask us to communicate with you about your confidential information by a different method or at another location. We will accommodate all reasonable requests.

- **To Be Notified of a Breach:** You will be notified in the event that unsecured protected health information is compromised.
- **To Receive Notice.** You are entitled to receive a copy of this notice that outlines our HIPAA privacy practices. We reserve the right to change these practices and the terms of this notice at any time. We will not make any material changes to our privacy practices without first sending you a revised notice. If you receive this notice on our web site or by electronic mail, you may request a paper copy.

IV. Who to Contact for Questions and Complaints

If you want more information about our privacy practices, wish to exercise any of your rights with regard to your PHI, or have any questions about the information in this notice, please use the contact information below. If you believe we may have violated your privacy rights, or if you disagree with a decision that we made in connection with your PHI, you may file a complaint using the contact information below. You may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. You may locate the regional office nearest to you by visiting their web site, http://www.hhs.gov/ocr/. We fully support your right to the privacy of your PHI, and will not retaliate in any way if you choose to file a complaint.

Mailing Address: **Sun Life Financial**
Privacy Officer
P.O. Box 419052
Kansas City, MO 64141-6052
Telephone: 800.733.7879
Email: SLF_US_Privacy@sunlife.com
Web Site: www.sunlife.com/us

For New York business:

Mailing Address: **Union Security Life Insurance Company of New York**
Privacy Officer
Administered by:
Sun Life Financial
P.O. Box 419052
Kansas City, MO 64141-6052
Telephone: 888.901.6377
Email: SLF_US_Privacy@sunlife.com

V. Organizations Covered by This Notice

This notice applies to the privacy practices of the organizations referenced below. These organizations may share your PHI with each other as needed for payment activities or health care operations relating to the healthcare plans that we provide.

VI. Effective Date of This Notice: April 14, 2003.

Revised: October 21, 2016

*** In this notice, "we," "us," and "our" refer to Union Security Insurance Company, Union Security Life Insurance Company of New York and the following prepaid dental companies:** DentiCare of Alabama, Inc., Union Security DentalCare of Georgia, Inc., UDC Dental California, Inc., UDC Ohio, Inc., United Dental Care of Arizona, Inc., United Dental Care of Colorado, Inc., United Dental Care of Michigan, Inc., United Dental Care of Missouri, Inc., United Dental Care of New Mexico, Inc., United Dental Care of Texas, Inc., United Dental Care of Utah, Inc., Union Security DentalCare of New Jersey, Inc.

Insurance products are underwritten by Union Security Insurance Company (USIC) (Kansas City, MO) and administered by Sun Life Assurance Company of Canada (SLOC) (Wellesley Hills, MA) in all states except New York. Prepaid dental products are provided by USIC and are administered by SLOC, and are provided by prepaid dental companies affiliated with SLOC in certain states except New York. Prepaid dental companies are

Denticare of Alabama, Inc., United Dental Care of Arizona, Inc., UDC Dental California, Inc., United Dental Care of Colorado, Inc., Union Security DentalCare of Georgia, Inc., United Dental Care of Missouri, Inc., Union Security DentalCare of New Jersey, Inc., United Dental Care of New Mexico, Inc., UDC Ohio, Inc., United Dental Care of Texas, Inc., and United Dental Care of Utah, Inc. In New York, insurance products and prepaid dental products are underwritten or provided by Union Security Life Insurance Company of New York (Fayetteville, NY) and administered by Sun Life and Health Insurance Company (U.S.) (Lansing, MI).

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SUMMARY PLAN DESCRIPTION

This Summary Plan Description is issued to you in compliance with the Employee Retirement Income Security Act of 1974 (ERISA). Included within this document is your Certificate of Insurance, issued by Union Security Insurance Company in compliance with state law. Your Summary Plan Description does not replace or modify the Master Policy issued by Union Security Insurance Company in any way. The Master Policy is the contract which sets forth the terms and conditions of the benefits the Plan Sponsor chose to provide in its welfare benefit plan. The Master Policy may be amended at any time by agreement between the Plan Sponsor and Union Security Insurance Company. The Master Policy may be terminated at any time by the Plan Sponsor or may be terminated by Union Security Insurance Company for non-payment of premium or for failure to meet the Master Policy's minimum participation requirements. The Plan Administrator has the obligation to prepare, issue, amend and file the Summary Plan Description (SPD) and is solely responsible for its contents.

GENERAL ADMINISTRATIVE PROVISIONS

Name of the Plan:

Meade School District 46-1

Plan Sponsor:

Meade School District 46-1
1230 Douglas
Sturgis, SD 57785
605.347.2649

Employer I.D. Number:

46-0307398

Type of Plan:

An employee welfare plan providing benefits for:

Vision Insurance
Vision Insurance for Dependents

Plan Number:

PN501 unless another number is assigned by the employer, the Plan Administrator, or on any Form 5500 filed for the Plan.

Effective Date:

The plan, as described in this SPD, became effective on January 1, 2017.

Any italicized terms are defined in the certificate, which is hereby incorporated by reference.

Who Is Eligible:

Eligible Class: For employee insurance - Each full-time employee of the *policyholder* or an *associated company*,

- who is at *active work*, and
- who is working in the United States of America,

as identified on the *policyholder's* or our records, except any temporary or seasonal worker.

For dependent insurance - Each *eligible dependent* of a person eligible and insured for employee insurance.

Present Service Requirement: None

Future Service Requirement: None

Entry Date: An eligible person will become insured on the first of the month occurring on or after the day all eligibility requirements are met.

Full-time means working at least 20 hours per week.

The plan may also cover other persons not included above. Check with the plan administrator.

Plan Administrator:

Meade School District 46-1
1230 Douglas
Sturgis, SD 57785
605.347.2649

Type of Administration:

This plan is insured by a contract with Union Security Insurance Company, 2323 Grand Boulevard, Kansas City, Missouri 64108-2670.

Amendment or Termination of Plan:

This plan may be amended or terminated at any time by the Plan Sponsor.

Agent for Service of Legal Process:

Meade School District 46-1
1230 Douglas
Sturgis, SD 57785
605.347.2649

Plan Records:

The fiscal records for the plan are kept on a policy year basis ending on the last day of December each year.

Cost of Benefits:

The premiums for the Vision Insurance plan for employees are paid for entirely by you.

The premiums for the Vision Insurance for Dependents plan are paid for entirely by you.

Your plan includes:

Vision Insurance
Vision Insurance for Dependents

The benefits, limitations and exclusions are described in the Certificate which is found within this Description.

STATEMENT OF ERISA RIGHTS

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

(i) Examine, without charge at the plan administrator's office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and, if required, 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.

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

(iii) 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.

(iv) Obtain, without charge, a copy of the plan’s procedures governing qualified medical child support order determinations.

(v) Obtain, automatically and without charge, a copy of your provider network list, if applicable to your plan.

(vi) 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.

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 our plan, called "fiduciaries" of the plan, have a duty to do so 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. If your claim for welfare benefits is denied 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 certain materials 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 may 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 legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. 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 the publications hotline of the Employee Benefits Security Administration.

NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. 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 and to other members of your family who are covered under the Plan when you would otherwise lose your group Vision coverage. 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. This notice gives only a summary of your COBRA continuation coverage rights.

The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of the 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. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, 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 will lose your coverage under the Plan because either one of the following qualifying events happens:

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

Your dependent spouse will become a qualified beneficiary if your dependent spouse loses coverage under the Plan because any of the following qualifying events happens:

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason other than gross misconduct; or
4. You become divorced or legally separated from your spouse.

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

1. You die;
2. Your hours of employment are reduced;
3. Your employment ends for any reason other than gross misconduct;
4. You become divorced or legally separated; or
5. The child stops being eligible for coverage under the Plan as a "dependent child".

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, or death of the employee, the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these 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. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to the Plan Administrator.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

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 losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage lasts for up to 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 at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator.

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, your spouse and dependent children can receive additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to your spouse and dependent children if you die or you get divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

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 to the Plan Administrator.

CLAIMS PROCEDURE

The following procedures apply to the extent benefits under your employee benefit plan are insured under a contract issued by Union Security Insurance Company.

PRESENTING A CLAIM

Contact your plan administrator, who will advise you of any forms which are required. These forms should be returned to the Plan Administrator after completion. This Administrator will review them, complete any information concerning eligibility and forward them to Union Security Insurance Company. Time limits for filing the claim and other requirements for notice and proof of loss may be found under the heading, "Filing A Claim".

NOTIFICATION OF DECISION— VISION

PRE-SERVICE CLAIMS

In the case of a PreService Claim, a decision will be made within 15 days after receipt by Union Security Insurance Company of a properly executed, complete proof of loss, unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. Such an extension of time may not exceed 15 additional days.

POST-SERVICE CLAIMS

A decision will be made within 30 days after receipt by Union Security Insurance Company of a properly executed, complete proof of loss, unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. Such an extension of time may not exceed 15 additional days.

NOTICE OF DENIAL

If the claim is denied in whole or in part, Union Security Insurance Company will provide written notice either directly to you or to the Plan Administrator for delivery to you. The written notice will contain:

1. The specific reason or reasons for the denial;
2. Specific reference to pertinent provisions of the policy upon which the decision is based;
3. A description of any additional material or information needed to perfect the claim and an explanation of why it is necessary; and
4. An explanation of the plan's claim review procedure.

REVIEW PROCEDURE—VISION

You are entitled to a full and fair review of denial of claim. You may make a request to the Plan Administrator or appropriate named fiduciary, if other than the Plan Administrator. The procedure is as follows:

1. The request for an initial review must be in writing and made within 180 days of receipt of written notice of denial;
2. You may review, upon request and free of charge, copies of all documents, records, and other information relevant to the claim for benefits. You have the right to review copies of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making our decision to deny your claim. You have the right to request that we identify all medical experts whose advice was obtained on behalf of the plan;
3. You have the right to submit issues and comments in writing, along with additional documents, records, and other information relating to the claim;

4. If our decision is based on necessity or experimental treatment or similar exclusion or limit, you have the right to an explanation of the scientific or clinical judgement for the determination, which will be provided upon request and free of charge;

5. The Plan Administrator will forward the request to Union Security Insurance Company;

6. Union Security Insurance Company will make a decision upon review within 15 days after receipt of the request in the event of a Pre-Service Claim and 30 days after receipt of the request in the event of a Post-Service Claim. The decision on review will be in writing, include the specific reasons for the decision and specific references to the pertinent plan provisions on which the decision is based and be furnished either directly to you or to the Plan Administrator for delivery to you.

7. You may request a second level appeal within 30 calendar days after receipt of the initial appeal response if you disagree with the response to your initial appeal. We will respond to you with our final determination in compliance with all applicable state and federal laws and regulations and will include the specific reasons for the determination.

Union Security Insurance Company
2323 Grand Boulevard
Kansas City, MO 64108

Policy 5482818
Participant 0
Booklet 1
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