Nippon Life Benefits®

CL MOORE & ASSOCIATES
SARAH J WEBER ACADEMY

EFFECTIVE SEPTEMBER 1, 2018

Group Plan Booklet Certificate

ALL MEMBERS

Vision Care Expense Insurance

In any discrepancy between this on-line Group Plan Booklet Certificate and the master contract, the master contract will govern. This on-line Group Plan Booklet Certificate does not guarantee benefits or eligibility. All terms, provisions, conditions, limitations, and exclusions shown in the Group Plan Booklet Certificate and master policy (including any supplements) will apply. Copies of the Group Plan Booklet Certificate may be obtained from the Plan Administrator.

A Tradition of Value, Humanity and Service
Nippon Life Insurance Company of America℠
www.nipponlifebenefits.com

Member's Signature

This insurance has been designed to provide financial help for a Member when a covered loss occurs. The insurance is established through a Group Policy issued by the Company, Nippon Life Insurance Company of America.

Member rights and benefits are determined by the provisions of the Group Policy. This booklet-certificate briefly describes those rights and benefits. It outlines what the Member must do to be insured. It explains how to file claims. It is the Member's booklet-certificate while they are insured.

THIS BOOKLET-CERTIFICATE REPLACES ANY PRIOR BOOKLET-CERTIFICATE THE MEMBER MAY HAVE RECEIVED. If the Member has any questions about this new booklet-certificate, please contact the Policyholder. In the event of future changes to the Member's insurance, he or she will be provided with a new booklet-certificate or a booklet-certificate rider.

If the Member has an electronic booklet-certificate, paper copies of this booklet-certificate are also available. Please contact the Policyholder to request a paper copy.

PLEASE READ THIS BOOKLET-CERTIFICATE CAREFULLY. The Company suggests starting with a review of the terms listed in the DEFINITIONS section on page NBV 136-1 (J) of this booklet-certificate. The meanings of these terms will help the Member understand the insurance.

The group insurance policy and the Member's insurance under the Group Policy may be discontinued or altered by the Policyholder or the Company at any time without the Member's consent.

The insurance provided in this booklet-certificate is subject to the laws of the state of Michigan.

NIPPON LIFE INSURANCE COMPANY OF AMERICA
P.O. Box 25951, Shawnee Mission, KS 66225-5951

BENEFIT ADVICE

THE COMPANY WANTS TO HELP THE INSURED PERSON BE A WISE VISION CARE CONSUMER. PLEASE CALL WITH ANY QUESTIONS ABOUT THIS VISION CARE INSURANCE.

English and Non-English Toll-Free Telephone Number: 1-800-374-1835 during normal business hours.

Japanese Toll-Free Telephone Number: 1-800-971-0638 during normal business hours.

Korean Toll-Free Telephone Number: 1-877-827-8713 during normal business hours.

REFER TO THE CLAIM PROCEDURES SECTION (PAGE NBV 146-1 (J)) OF THIS BOOKLET-CERTIFICATE FOR MORE DETAILED INFORMATION.

BOOKLET-CERTIFICATE TABLE OF CONTENTS

SUMMARY OF BENEFITS
(Effective September 1, 2018)

VISION CARE EXPENSE INSURANCE

This section highlights the benefits provided under this insurance. The purpose is to give the Insured Person quick access to the information he or she will most often want to review. **Please read the other sections of this booklet-certificate for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

Scheduled Benefits are based on the Member's Class and the status of his or her Dependents:

Class	Scheduled Benefit
All Members and their Dependents	As shown below

PREFERRED PROVIDER ORGANIZATION (PPO)

The Policyholder participates in a Preferred Provider Organization (PPO) network established and administered by the PPO shown on the Insured Person's identification card.

Preferred Provider Organization networks are arrangements whereby Physicians and other providers are contracted to furnish, at negotiated costs, vision care for Members of participating Policyholders.

It is expected that the Policyholder's participation in the PPO will result in significant savings of funds needed to maintain the Member's insurance. These savings are to be passed on to the Member in the form of higher benefits payable for Covered Charges received by Insured Persons from Preferred Providers.

Please note that the Policyholder's participation in the PPO network does not mean that the Insured Person's choice of provider will be restricted. The Insured Person may still seek needed vision care from any Ophthalmologist, Optometrist or Optician he or she wishes. However, in order to avoid higher charges and reduced benefit payments, the Insured Person is urged to obtain such care from Preferred Providers whenever possible.

A current listing of the participating providers is available through an on-line Preferred Provider directory. By accessing the Nippon Life Insurance Company of America website at www.nipponlifebenefits.com, the Insured Person can review Preferred Provider directories for the PPO Network. If the Insured Person does not have internet access, the Insured Person can call the number on the Insured Person's ID card. The Company recommends that the Insured Person (1) verify his or her provider's participation in the network before seeking treatment; and (2) confirm the provider's PPO participation when making an appointment.

VISION CARE EXPENSE INSURANCE

BENEFITS PAYABLE

Benefits will be payable for Treatment or Service received on a Rolling Benefit Plan basis as shown below.

Visual Service or Vision Materials Per Insured Person	
Benefit Frequency	
Complete Visual Analysis/Vision Exam	Once per 12 consecutive months
Standard Plastic Lenses or Contact Lenses	Once per 12 consecutive months
Frames	Once per 24 consecutive months

Benefits and Discounts	**PPO Providers (Insured Person cost)**	**Non-PPO Providers (*Reimbursement)**
Complete Visual Analysis/Vision Exam with Dilation if necessary	$10 Copay	$30
Retinal Imaging	up to $39 discount	No Benefits Payable
Contact Lens Fitting		
- Standard	up to $40 discount	No Benefits Payable
- Premium	10% discount off retail price	No Benefits Payable
Frames (Any available frame at provider location)	$130 Allowance, then 20% discount off balance over $130	$65
Standard Plastic Lenses		
- Single Vision Lens	$10 Copay	$15
- Bifocal Lens	$10 Copay	$23
- Trifocal Lens	$10 Copay	$40
- Lenticular Lens	$10 Copay	$40
- Standard Progressive Lens	$75 Copay	$23
- Premium Progressive Lens		
Tier 1	$95 Copay	$23

Benefits and Discounts	PPO Providers (Insured Person cost)	Non-PPO Providers (*Reimbursement)
Tier 2	$105 Copay	$23
Tier 3	$120 Copay	$23
Tier 4	$75 Copay, then 80% of charge less $120 Allowance	$23
Lens Options		
- UV Coating	$15	No Benefits Payable
- Tint (Solid and Gradient)	$15	No Benefits Payable
- Standard Plastic Scratch Coating	$0	$5
- Standard Polycarbonate – Insured Persons age 19 and older	$40	No Benefits Payable
- Standard Polycarbonate - Dependent Children under age 19	$0	$20
- Anti-Reflective Coating - Standard	$45	No Benefits Payable
- Polarized	20% discount off retail price	No Benefits Payable
- Photochromic/Transitions Lens	$75	No Benefits Payable
- Anti-Reflective Coating - Premium		
Tier 1	$57	No Benefits Payable
Tier 2	$68	No Benefits Payable
Tier 3	80% of charge	No Benefits Payable
- Other Add-Ons	20% discount off retail price	No Benefits Payable
Contact Lenses (in lieu of the Standard Plastic Lens benefit) This benefit provides coverage for the Vision Materials only. It does not include the Contact Lens Fitting.		
- Conventional	$0 Copay, $130 Allowance, then 15% discount off balance over $130	$104

Benefits and Discounts	PPO Providers (Insured Person cost)	Non-PPO Providers (*Reimbursement)
- Disposable	$0 Copay, $130 Allowance, then balance over $130	$104
- Medically Necessary	$0 Copay	$210
** Laser Vision Correction		
- Lasik or PRK from U.S. Laser Network	15% discount off retail price or 5% discount off promotional price	No Benefits Payable
Additional Pairs Benefit	40% discount off the purchase of an additional pair of Standard Plastic Lens and frames and a 15% discount off the purchase of an additional pair of conventional Contact Lenses each 12 consecutive months, once the benefit above has been utilized.	No Benefits Payable

*Reimbursement for a Non-PPO Provider will be the lesser of the amount shown above or the actual cost from Non-PPO Provider.

Discounts are not applicable to Visual Services or Vision Materials provided by Non-Preferred Providers. Discounts described above are not insured benefits. Discounts do not apply to benefits provided by other group benefit plans. Discounts may not be combined with any other discounts or promotional offers, and the discount does not apply to Preferred Provider professional services, disposable Contact Lenses or certain brand name Vision Materials in which the manufacturer imposes a no-discount practice or policy.

**For additional information or to locate a network provider, visit www.eyemedlasik.com or call 1-877-5LASER6.

The Contact Lenses benefit will be in lieu of the Standard Plastic Lens and frame benefit. If Contact Lenses are chosen, there will be no benefits payable for the Standard Plastic Lens benefit for a period of 12 consecutive months from the date of service and there will be no benefits payable for the frame benefit for a period of 24 consecutive months from the date of service.

Lens Options or Add-Ons listed above as a Covered Visual Service or Vision Material are paid for in addition to the Standard Plastic Lenses, as indicated above. Lens Options or Add-Ons that are not a Covered Visual Service or Vision Material, or that exceed the stated maximums, are the Insured Person's responsibility to pay to the provider.

Allowance

The Allowances for an Insured Person during any period of 12 consecutive months (24 months for frames) will not exceed the Allowances shown in this section. Benefit Allowances provide no remaining balance for future use within the same benefit frequency.

See page NBV 622-1 (J) for a complete description of Vision Care Expense Insurance.

HOW TO BE INSURED – MEMBERS

VISION CARE EXPENSE INSURANCE

Eligibility

Persons enrolling for insurance must be a Member who Resides in the United States.

If the person is a Member on September 1, 2018, the person will be eligible on that date.

If the person is not a Member until later, the person will be eligible on the first of the Insurance Month coinciding with or next following the date the person completes the Eligibility Waiting Period.

The Eligibility Waiting Period is a period of 30 days during which the person is continuously Actively at Work.

If a person elects to waive insurance under the Group Policy because such person is covered under group vision care expense coverage or coverages provided by a Dependent's employer, the date such coverage terminates because that Dependent is no longer eligible under his or her employer's coverage will be considered the date the person is eligible to request insurance as described in this section. Termination of coverage that has been continued under any state or federal continuation provisions will not be considered as a qualifying event for the purpose of these provisions.

Effective Dates - Actively at Work

If the Member is not Actively at Work on the date the Member's insurance would otherwise be effective, the Member's insurance will not be in force until the day the Member returns to Active Work.

This Actively at Work requirement will be waived for the Member if:

- the Member is absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and
- the Member was Actively at Work on the last scheduled work day before the date of the absence; and
- the Member was capable of Active Work on the day before the scheduled effective date of the insurance or change in the insurance, whichever is applicable.

Individual Incontestability and Eligibility

All statements made by any person insured will be representations and not warranties. In the absence of fraud, these statements may not be used to contest the Insured Person's insurance unless:

- the insurance has been in force for less than two years during the Insured Person's lifetime; and
- the statement is in Written form Signed by the Insured Person; and
- a copy of the form which contains the statement is given to the Insured Person or the Insured Person's beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if a person's age is misstated, the Company may, at any time, adjust premiums and benefits to reflect the correct age.

Effective Date for Initial Insurance

The Member must request initial insurance on a form provided by the Company.

If the Member is required to contribute towards the cost of his or her insurance, insurance will normally be in force on:

- the date the Member is eligible, if he or she makes the request on or before that date; or
- the first of the Insurance Month coinciding with or next following the date of the Member's request, if he or she makes the request within 31 days after the date such person is eligible**.**

If request for contributory insurance is made more than 31 days after the date an individual is eligible but as a result of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), insurance for such individual will become effective as described below.

If request for contributory insurance is made more than 31 days after the date a Member is eligible and other than during an Annual Open Enrollment Period or a Special Enrollment Period described below, insurance for such Member will become effective as described below for Late Enrollees.

If request for contributory insurance is made more than 31 days after the date a Member is eligible but during an Annual Open Enrollment Period described below, insurance for such Member will become effective as described below under Annual Open Enrollment Period.

If request for contributory insurance is made more than 31 days after the date a Member is eligible but during a Special Enrollment Period described below, insurance for such Member will become effective as described below under Special Enrollment Period.

If the Member is not required to contribute toward the cost of his or her insurance, insurance will normally be in force on the date the Member is eligible.

However, if the Member is not Actively at Work on the date insurance would otherwise be effective, his or her insurance will not be in force until the date he or she returns to Active Work.

Effective Date for Late Enrollees

If a Late Enrollee requests insurance other than during an Annual Open Enrollment Period or a Special Enrollment Period, the effective date of insurance for the Late Enrollee will be the day immediately following completion of the Annual Open Enrollment Period, provided on such date:

- the Member continues to meet the Group Policy's definition of a Member; and
- for Dependent insurance, the Dependent continues to meet the Group Policy's definition of Dependent.

Annual Open Enrollment Period

An Annual Open Enrollment Period will be available for any Member or Dependent who failed to enroll:

- during the first period in which he or she was eligible to enroll, or during any subsequent Special Enrollment Period as described below; or
- during any previous Annual Open Enrollment Period; or
- within 31 days after the termination date, if the individual was previously insured under the Group Policy but elected to terminate the insurance.

To qualify for enrollment during the Annual Open Enrollment Period, the Member or Dependent:

- must meet the eligibility requirements described in the Group Policy; and
- may not be covered under an alternate vision care expense coverage offered by the Policyholder, unless the Annual Open Enrollment Period happens to coincide with a separate open enrollment period established for coverage election.

The Annual Open Enrollment Period is the one-month period immediately prior to the Policy Anniversary date. The Policy Anniversary date is September 1.

The effective date for any qualified individual requesting insurance during the Annual Open Enrollment Period will be the day immediately following completion of the Annual Open Enrollment Period.

Court Ordered Coverage Under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN): A Special Enrollment Period provision described below will not apply to the Member or his or her Dependent Child if:

- the Member is enrolled (or eligible to be enrolled but had failed to enroll during a previous enrollment period); and
- the Member failed to enroll his or her Dependent Child during a previous enrollment period; and
- the Member is required by a QMCSO or NMSN as defined by federal law and state insurance laws to provide vision care coverage for his or her Dependent Child.

The request for enrollment:

- may be made at any time after the issue date of the QMCSO or NMSN; and
- will apply only to the Member and/or his or her Dependent Child(ren) listed in the QMCSO or NMSN.

The effective date for the Member's or his or her Dependent Child's insurance:

- will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment; and
- will not be subject to the Actively at Work provisions described in this section.

A request for enrollment for any Dependent not listed in the QMCSO or NMSN will be subject to the regular effective date provisions of the Group Policy.

A copy of the procedures governing qualified medical child support orders (QMCSO) can be obtained from the plan administrator without charge.

Special Enrollment Period

A Special Enrollment Period will be available for a Member or Dependent if enrollment is made after the first period in which the Member or Dependent are eligible to enroll.

The Special Enrollment Periods are:

- Loss of Other Coverage. A Special Enrollment Period will apply to the Member or Dependent if all of the following conditions are met:

  - the Member was covered under another group vision care expense coverage at the time of his or her initial eligibility, and declined enrollment solely due to the other coverage; and
  - the other coverage terminated due to loss of eligibility (including loss due to divorce or legal separation, death, termination of employment or reduction in work hours, or if the other coverage was under COBRA or a state continuation provision, due to exhaustion of the continuation); and
  - request for enrollment is made within 31 days after the other coverage terminates.

  The effective date of insurance will be the first of the Insurance Month coinciding with or next following the date of the request for enrollment provided contribution has been received for the requested insurance.

  "Loss of eligibility" does not include:

  - a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the vision care expense coverage); or
  - a loss due to a spouse's voluntary termination of his or her vision care expense coverage; or
  - a loss due to a spouse's voluntary termination of his or her Dependent vision care expense coverage.

- Newly Acquired Dependents. A Special Enrollment Period will apply to the Member or Dependent if:

  - the Member is enrolled (or is eligible to be enrolled but failed to enroll during a previous enrollment period); and
  - a person becomes the Member's Dependent through marriage, birth, adoption or Placement for Adoption; and
  - request for enrollment is made within 31 days after the later of the date of the marriage, birth, adoption or Placement for Adoption, or the date Dependent Vision Care Expense Insurance is available to the Member under the Group Policy.

  The effective date of the Member's or Dependent's insurance will be:

  - in the event of marriage the date of such marriage; or
  - in the event of a Dependent Child's birth, the date of such birth; or

- in the event of a Dependent Child's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption, whichever is earlier.

Effective Date for Benefit Changes

A change in the Member's Scheduled Benefit amount because of a change in status (insurance class) will normally be effective on the first of the Insurance Month coinciding with or next following the date of change in status.

A change in the Member's Scheduled Benefit amount because of a change in benefits provided under the Group Policy will normally be effective on the first of the Insurance Month coinciding with or next following the date of the change.

However, if the Member is not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day he or she returns to Active Work.

Termination

Unless continued as provided below or on page NBV 117 B-1 (J), NBV 117 C-1 (J), and NBV 117 D-1 (J), a Member's insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- for contributory insurance, the end of the Insurance Month, if requested by the Member before that date; or
- the end of the Insurance Month in which the Member ceases to belong to a class for which insurance is provided; or
- the end of the Insurance Month in which the Member ceases to be a Member; or
- the end of the Insurance Month in which the Member ceases Active Work.

Termination for Fraud

The Company may, at any time, terminate an Insured Person's eligibility under the Group Policy:

- in Writing and with 31 day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law;
- in Writing and with 31 day notice, upon finding in a civil or criminal case that an Insured Person has submitted claims that contain false or fraudulent elements under state or federal law;
- in Writing and with 31 day notice, when an Insured Person has submitted a claim which, in good faith judgment and investigation, an Insured Person knew or should have known, contains false or fraudulent elements under state or federal law.

Termination of Preferred Provider Organization (PPO)

The Company has the right to terminate the Preferred Provider Organization (PPO) portion of the Group Policy if the Company or the Preferred Provider Organization (PPO) terminates the arrangement.

The Company also has the right to identify different Preferred Provider Organizations from time to time and to terminate the designation of any Preferred Provider at any time.

Termination of Insurance While Outside of the United States

If the Member is outside the United States, his or her insurance will automatically terminate. However, the Member will continue to be eligible for benefits provided under the Group Policy if the Member is temporarily outside of the United States for a period of six months or less for one of the following reasons:

- travel, provided the travel is for a reason other than securing vision care diagnosis or treatment; or
- a business assignment; or
- Full-Time Student status, provided the Insured Person is either:
  - enrolled and attending an accredited school in a foreign country; or
  - participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U. S. grants academic credit.

Continuation

If the Member ceases Active Work because he or she is sick or injured, he or she may be eligible for limited continuation of insurance for not more than six consecutive months.

If the Member ceases Active Work because of layoff or approved leave of absence, insurance may be continued on a limited basis for up to one month.

If insurance under the Group Policy is subject to COBRA or USERRA, this continuation period will run concurrent with the COBRA or USERRA period.

The Member's insurance may also be continued by paying the required contribution, if any, under the continuation provisions described on page NBV 117 B-1 (J), NBV 117 C-1 (J), and NBV 117 D-1 (J).

All continuation provisions may run concurrently.

If the Member is interested in continuing his or her insurance beyond the date it would normally terminate, he or she should consult with the Policyholder before his or her insurance terminates.

Contact the Policyholder with reinstatement questions.

HOW TO BE INSURED - DEPENDENTS

VISION CARE EXPENSE INSURANCE

Eligibility

A Member's spouse must Reside in the United States to be eligible for Dependent insurance.

A Member will be eligible for Dependent insurance on the latest of:

- the date the Member is eligible for Member insurance; or
- the date the Member enters a class for which Dependent insurance is provided; or
- the date the Member first acquires a Dependent.

If the Member's Dependent is employed and is covered under group coverage provided by his or her employer, the date such coverage is terminated because the Member's Dependent is no longer eligible under his or her employer's plan will be considered the date the Member first acquired that Dependent (and any other Dependent who was also covered under such coverage). Termination of coverage that has been continued under any state or federal continuation provisions will not be considered as a qualifying event for the purpose of these provisions.

Effective Date

Dependent insurance is available only with respect to Dependents of Members currently insured for Member insurance. If a Member is eligible for Dependent insurance, such insurance for his or her Dependents will be in force under the same terms as described earlier for Member insurance, except:

- a Dependent acquired after the Member's Dependent insurance is already in force will be insured on the date acquired.
- the Actively at Work requirement does not apply to the Member's Dependents.

Individual Incontestability and Eligibility

Dependents will be subject to the Individual Incontestability and Eligibility provision as described earlier for Member insurance.

Annual Open Enrollment Period

Dependents will be subject to the Annual Open Enrollment Period provisions as described earlier for Member insurance.

Special Enrollment Period

Dependents will be subject to the Special Enrollment Period provisions as described earlier for Member insurance.

Termination

Unless continued as provided on page NBV 117 B-1 (J), NBV 117 C-1 (J), and NBV 117 D-1 (J):

- Insurance for all of the Member's Dependents will terminate on the earliest of:
    - the end of the Insurance Month in which the Member ceases to belong to a class for which Dependent insurance is provided; or
    - the date Dependent insurance is removed from the Group Policy; or
    - the date the Member's insurance ceases; or
    - the end of the Insurance Month in which the last premium is paid for the Member's Dependent Vision Care Expense Insurance; or

- Insurance for a spouse or Dependent Child, will terminate on the earlier of:
    - for contributory insurance, the end of any Insurance Month, if requested by the Member before that date; or
    - the last day of the Insurance Month in which a spouse or Dependent Child ceases to be a Dependent as defined in NBV 136-1 (J). However, a spouse who no longer resides with the Member will not cease to be a Dependent until legally separated or divorced, provided the spouse otherwise continues to be a Dependent as defined in page NBV 136-1 (J).

Notwithstanding the above, insurance will terminate on the last day of the calendar month in which the Member's Dependent Child turns age 26.

However, Vision Care Expense Insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap and is dependent on the Member for primary support. The Member must apply for this continuation within 31 days after the child reaches the maximum age.

Termination for Fraud

Dependents will be subject to the Termination for Fraud provisions as described earlier for Member insurance.

Insurance While Outside of the United States

Dependents will be subject to the Insurance While Outside of the United States provisions as described earlier for Member insurance.

Continuation

Under certain conditions, Dependent Vision Care Expense Insurance may be continued after the date it would normally terminate. See the continuation provisions described on page NBV 117 B-1 (J), NBV 117 C-1 (J), and NBV 117 D-1 (J).

COBRA CONTINUATION

Federal Required Continuation - Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to any employer (except the federal government and religious organizations) that: (a) maintains group vision coverage; and (b) normally employed 20 or more employees on a typical business day during the preceding calendar year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

Where applicable, COBRA requires that group health insurance allow qualified persons (described below) to continue group health coverage after it would normally end. The term "group health coverage" includes any medical, dental, vision care, and prescription drug coverages that are part of the insurance.

A. Qualified Persons/Qualifying Events

Continuation of group vision coverage must be offered to the following persons if they would otherwise lose that coverage as a result of the following qualifying events:

(1) A Member (and any covered Dependents) following the Member's:

(a) termination of employment for a reason other than gross misconduct; or
(b) a reduction in work hours.

Reduction in work hours includes, but is not limited to, leave of absence, layoff, absence due to sickness or injury, or, when applicable, retirement.

(Note: Taking a family or medical leave under the Federal Family & Medical Leave Act (FMLA) is not a qualifying event under COBRA. A Member has a qualifying event when the Member does not return to work after the end of FMLA leave); and

(2) A Member's former spouse (and any Dependent Children) following a divorce or legal separation from the Member; and
(3) A Member's surviving spouse (and any Dependent Children) following the Member's death; and
(4) A Member's Dependent Child following loss of status as a Dependent under the terms of the Group Policy (e.g., attaining the maximum age, marriage, joining the armed forces, etc.); and
(5) A Member's spouse (and any Dependent Children) following the Member's entitlement to Medicare; and

(6) A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation due to termination of employment or reduction in work hours; and
(7) If the Group Policy covers retired Members, a retired Member and his/her Dependents (or surviving Dependents) when retiree vision benefits are "substantially eliminated" or terminated within one year before or after the employer files Chapter 11 (United States Code) bankruptcy proceedings.

B. Maximum Continuation Period

Following a qualifying event, vision coverage can continue up to the maximum continuation period. The maximum continuation period for a Member (and any Dependents) following a termination of employment or reduction in work hours is 18 months from the date of the qualifying event. The maximum continuation period for a Member's Dependent Child that is born to or placed for adoption with the Member while on COBRA continuation will extend to the end of the Member's maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request an 11-month extension of COBRA continuation. The maximum COBRA continuation will be 29 months from the date of the qualifying event (see Disabled Extension, Section D).

When a Member becomes entitled to Medicare before employment terminates or work hours are reduced, the maximum continuation period for the Dependents will be the longer of:

(1) 36 months dating back to the Member's entitlement to Medicare; or
(2) 18 months from the date of the qualifying event (termination of employment or reduction in work hours).

The maximum continuation period for qualified Dependents following a qualifying event described in A(2) through A(5) is 36 months from the date of the qualifying event.

If the Group Policy covers retired Members and the qualifying event is the employer's bankruptcy filing, the following rules apply:

(1) If the retired Member is alive on the date of the qualifying event, the retired Member and his or her spouse and Dependent Children may continue coverage for the life of the retired Member. In addition, if the retired Member dies while covered under COBRA, the spouse or Dependent Children may continue coverage for an additional 36 months.
(2) If the retired Member is not alive on the date of the qualifying event, his or her spouse may continue coverage to the date of his or her death.

C. Second Qualifying Events

If during an 18-month continuation period (or, 29 months for qualified persons on the disabled extension), a second qualifying event described in A(2) through A(5) occurs, the maximum continuation period may be extended for the qualified Dependents up to 36 months. That is, following a second qualifying event, qualified Dependents may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in A(2) through A(5), absent the first qualifying event, would result in a loss of coverage for Dependents under the Group Policy. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption.

D. Disabled Extension

Following a termination of employment or reduction in work hours, a qualified person (Member or Dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after the qualifying event may request an extension of the continued coverage from 18 months to 29 months. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation must be determined disabled by the Social Security Administration within 60 days after the date of birth or placement for adoption. The disabled extension also applies to each qualified person (the disabled person and any family members) who is not disabled and who is on COBRA continuation as a result of termination of employment or reduction in work hours.

The 11-month extension for all qualified persons will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end as outlined in Section E below.

E. Termination of Continued Coverage

Continued coverage ends on the earliest of the following:

(1) The date the maximum continuation period ends; or
(2) The date the qualified person enrolls in Medicare; however, this does not apply to a person who is already enrolled in Medicare on the date he or she elects COBRA or to a person who is on COBRA due to the employer's bankruptcy filing as described in A(7); or
(3) The end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section I.); or
(4) The date the Group Policy is terminated (and not replaced by another group vision plan); or

(5) The date the qualified person becomes covered by another group vision plan; however, this does not apply to a person who is already covered by the other group vision plan on the date he or she elects COBRA.

Note: Persons who, after the date of COBRA continuation election, become entitled to Medicare or become covered under another group vision plan are not eligible for continued coverage. However, if the Group Policy covers retired Members, continued coverage for retired persons and their Dependents (or surviving Dependents) due to qualifying event A(7) above may not be terminated due to Medicare coverage.

F. Employer/Plan Administrator Notification Requirement

When a Member or Dependent has a qualifying event due to termination of employment, reduction in work hours, death of the Member, the Member's entitlement to Medicare, or if the Group Policy covers retired Members, the commencement of the employer's Chapter 11 (United States Code) bankruptcy proceedings, the employer must notify the plan administrator within 30 days of the date of the qualifying event. The plan administrator must notify the qualified person of the right to COBRA continuation within 14 days after receiving notice of a qualifying event from the employer.

G. Qualified Person Notice and Election Requirements

Qualified persons must notify the plan administrator within 60 days after (a) the date of a qualifying event (i.e., divorce, legal separation, or a child ceases to be a Dependent Child under the terms of the Group Policy); (b) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (c) the date the qualified person is first informed of this notice obligation; otherwise the right to COBRA continuation ends. This 60-day notice period applies to initial and second qualifying events.

Qualified persons who request an extension of COBRA due to disability must submit a Written request to the plan administrator before the 18-month COBRA continuation period ends and within 60 days after the latest of the following dates: (a) the date of disability determination by the Social Security Administration; (b) the date of the qualifying event; (c) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (d) the date the qualified person is first informed of this notice obligation; otherwise the right to the disabled extension ends. Qualified persons must also notify the plan administrator within 30 days after the date the Social Security Administration determines the qualified person is no longer disabled.

Notification of a qualifying event to the plan administrator must be in Writing and must include the following information: (a) name and identification number of the Member and each qualified beneficiary; (b) type and date of initial or second qualifying event; (c) if the notice is for an extension due to disability, a copy of any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the plan administrator may contact if additional information is needed to determine COBRA rights.

Within 14 days after receiving notice of a qualified event from the qualified person, the plan administrator must provide the qualified person with an election notice.

Qualified persons must make Written election within 60 days after the later of: (a) the date group vision coverage would normally end; or (b) the date of the plan administrator's election notice. The election notice must be returned to the plan administrator within this 60-day period; otherwise the right to elect COBRA continuation ends.

Each qualified person has an independent right to elect COBRA. A covered Member may elect COBRA continuation on behalf of his/her covered spouse. A covered Member, parent, or legal guardian may elect COBRA continuation on behalf of his/her covered Dependent Children.

To protect COBRA rights, the plan administrator must be informed of any address changes for covered Members and Dependents. Retain copies of any notices sent to the plan administrator.

H. Monthly Cost

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage (COBRA permits the inclusion of a 2% billing fee). Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person can be required to continue to pay 102% of the cost for the applicable coverage during the disability extension. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay 148% of the cost for the applicable coverage (plus a 2% billing fee) for the 19th through the 29th month of coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

I. Grace Period

Qualified persons have 45 days after the initial election to remit the first payment. The first payment must include all payments due when sent. All other payments (except for the first payment) will be timely if made within the Grace Period. "Grace Period" means the first 31-day period following a premium due date. Except for the first payment, a Grace Period of 31 days will be allowed for payment of premium. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

J. Policy Changes

Continued coverage will be subject to the same benefits and rate changes as the Group Policy.

K. Newly Acquired Dependents

A qualified person may elect coverage for a Dependent acquired during COBRA continuation. All enrollment and notification requirements that apply to Dependents of active Members apply to Dependents acquired by qualified persons during COBRA continuation.

Coverage for a newly acquired Dependent will end on the same dates as described for qualified persons in Section B above. Exception: Coverage for newly acquired Dependents, other than the Member's Dependent Child who is born to or placed for adoption with the Member, will not be extended as a result of a second qualifying event.

L. Important Note for Members or Dependents eligible for Medicare Part B (or Part C)

Members or Dependents who are eligible for COBRA and who are age 65 or older, or who are disabled, should enroll in Medicare Part B (or Part C) because Medicare is the primary payer for health care expenses. In this instance, the Group Policy pays secondary whether or not the Member or Dependent is actually enrolled in Medicare Part B (or Part C). Therefore, failure to enroll in Medicare Part B (or Part C) will result in significant benefit reductions.

Medicare is the primary payer under other circumstances as well. Please consider vision enrollment options carefully.

M. Contact Information

To notify the plan administrator of an initial or second qualifying event, request a disabled extension, request termination of COBRA, change of address, or request additional information concerning the Group Policy or COBRA, contact the following:

Group Vision Plan: CL MOORE & ASSOCIATES SARAH J WEBER ACADEMY Vision Plan
Contact Name/Area: CL MOORE & ASSOCIATES SARAH J WEBER ACADEMY Benefits Department
Address: 530 S PINE ST
LANSING, MI 48933
Phone Number: 5173717876

FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects the Group Policy. Contact the Policyholder for details on this continuation provision.

FMLA and Other Continuation Provisions

If the Policyholder is an Eligible Employer and if the continuation portion of the FMLA applies to the Eligible Employee's insurance, these FMLA continuation provisions:

- Are in addition to any other continuation provisions of the Group Policy, if any; and
- Will run concurrently with any other continuation provisions of the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

Mandated Unpaid Leave

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- the birth of a child of an Eligible Employee and in order to care for the child;
- the placement of a child with the Eligible Employee for adoption or foster care;
- to care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition";
- a "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job; or
- because of a “qualifying exigency” arising out of a spouse, son, daughter or parent on active duty or having been notified of a call to active duty, as applicable to retired regular armed forces members, reserve members, National Guard members, and members in contingency operations, as defined under federal law.

Eligible Employers are required to allow up to a total of 26 workweeks of unpaid leave during any 12 month period to Eligible Employees to care for a “covered service member” with a “serious injury or illness”.

Reinstatement

An Eligible Employee's terminated insurance may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA), subject to the Actively at Work requirements of the Group Policy.

Contact the Policyholder for details on this reinstatement provision.

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

Federal law requires that if insurance would otherwise end because the Member enters into active military duty or inactive military duty for training, he or she may elect to continue insurance (including Dependents insurance) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation

If Active Work ends because the Member enters active military duty or inactive military duty for training, insurance may be continued until the earliest of:

- for the Member and Dependents:
    - the date the Group Policy is terminated; or
    - the end of the premium period for which premium is paid if the Member fails to make timely payment of a required premium; or
    - the date 24 months after the date the Member enters active military duty; or
    - the date after the day in which the Member fails to return to Active Work or apply for reemployment with the Policyholder.
- for the Member's Dependents:
    - the date Dependent Vision Care Expense Insurance would otherwise cease as provided on page NBV 125-1 (J); or
    - the end of any Insurance Month, if requested by the Member before that date.

The continuation provision will be in addition to any other continuation provisions described in the Group Policy for sickness, injury, layoff, or approved leave of absence, if any. If the Member qualifies for both state and USERRA continuation, the election of one means the rejection of the other.

Reinstatement

The reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA. The Actively at Work provision, described in the Group Policy, will not apply to the reinstated insurance.

This is a general summary of the USERRA and how it affects the Group Policy. Contact the Policyholder for details on this continuation provision.

DESCRIPTION OF BENEFITS

VISION CARE EXPENSE INSURANCE (PAYMENT PROVISIONS)

Benefit Qualification

To qualify for payment of the benefits provided by the Group Policy for an insured class, the Member and his or her Dependents must:

- be insured in that class on the date vision Treatment or Service is received; and
- satisfy the requirements listed in the CLAIM PROCEDURES section as described on page NBV 146-1 (J).

Benefits Payable

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- the terms and conditions of COORDINATION WITH OTHER BENEFITS as described on page NBV 156-1 (J).

DESCRIPTION OF BENEFITS

VISION CARE EXPENSE INSURANCE

If the Member or Dependent undergoes a Complete Visual Analysis/Vision Exam or purchases any of the listed Vision Materials, the Company will pay the vision care benefits for Covered Charges as described in the SUMMARY OF BENEFITS section on page NBV 102-1 (J) (PPO).

Covered Charges

Covered Charges will be the actual cost charged to the Member or Dependent for Treatment or Service for the listed procedures shown in the SUMMARY OF BENEFITS section. Also:

- Covered Charges will include only those charges for Treatment or Service that begins (see below) while the Member and Dependents are insured under the Group Policy.
- Covered Charges will include only those charges for Treatment or Service that is completed while the Member and Dependents are insured under the Group Policy, except for Vision Materials ordered before insurance ended are delivered, and the Treatment or Service is rendered to the Insured Person within 31 days from the date of such order.

Limitations

Vision Care Expense benefits will not be paid for:

- a visual analysis/Vision Exam or Vision Materials that are not Medically Necessary; or
- Visual Services or Vision Materials that are not specifically listed as a Covered Charge in the Summary of Benefits; or
- a Visual Service performed by other than an Ophthalmologist, Optometrist or Optician; or
- Vision Materials not prescribed by an Ophthalmologist or Optometrist; or
- a Visual Service or Vision Materials provided by any person in the Member's or Dependent's Immediate Family; or
- Plano Lens or non-prescription lenses or non-prescription sunglasses; or
- duplication or replacement of a Vision Material that is broken, lost, or stolen; or
- more than one Complete Visual Analysis/Vision Exam in any period of 12 consecutive months, regardless if Medically Necessary; or
- more than once in any period of 12 consecutive months for Standard Plastic Lenses or Contact Lenses or once in any period of 24 consecutive months for frames, regardless if Medically Necessary; or
- any additional Visual Service outside a basic Vision Exam for Contact Lenses, except for Contact Lens Fitting; or
- hearing exams and hearing aids; or
- laser vision correction; or

- solutions and/or cleaning products for Standard Plastic Lenses or glass lens or Contact Lenses; or
- frame cases; or
- low (subnormal) Vision Materials or aniseikonic lenses; or
- Orthoptics, vision training and any associated supplemental testing; or
- any eye exam or corrective eyewear required by the Policyholder as a condition of employment, including but not limited to industrial or safety glasses; or
- Visual Services or Vision Materials provided by another vision plan or any group medical expense coverage; or
- two pairs of Standard Plastic Lenses or glass lens, in lieu of Bifocal Lens, Trifocal Lens, Premium Progressive Lens or Standard Progressive Lens; or
- cosmetic items; or
- additional cost for Visual Services or Vision Materials over the Allowance; or
- experimental or non-conventional treatment or device; or
- a Visual Service or Vision Materials for which the Member or Dependent has no financial liability or that would be provided at no charge in the absence of insurance; or
- a Visual Service or Vision Materials that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- a Visual Service or Vision Materials provided as the result of a sickness or injury that is due to war or act of war when the Insured Person is a member of the armed forces; or
- a Visual Service or Vision Materials provided as the result of the Insured Person's commission of or attempt to commit a felony, or to which a contributing cause was the Insured Person's being engaged in an illegal occupation or other willful criminal activity rising to the level of a misdemeanor or felony; or
- a Visual Service or Vision Materials provided as the result of:

    - an injury arising out of or in the course of any employment for wage or profit, if the Member or Dependent is eligible to be covered under a Workers' Compensation Act or other similar law; except this limitation will not apply to: partners, proprietors, or corporate officers of the Policyholder who are not covered by a Workers' Compensation Act or other similar law; or
    - a sickness covered by a Workers' Compensation Act or other similar law; or

- a Visual Service or Vision Materials provided outside the United States, unless the Insured Person is temporarily outside the United States for a period of six months or less for one of the following reasons:

    - travel, provided the travel is for a reason other than securing vision care diagnosis or treatment; or
    - a business assignment; or

- Full-Time Student status, provided the Insured Person is either:

    - enrolled and attending an accredited school in a foreign country; or
    - participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit; or

- medical or surgical treatment of the eye, eyes, or supporting structures, unless such treatment is performed during a Complete Visual Analysis/Vision Exam, subject to the applicable Complete Visual Analysis/Vision Exam maximum benefit shown in the SUMMARY OF BENEFITS section.

VISION CARE EXPENSE INSURANCE

COORDINATION WITH OTHER BENEFITS

Applicability

These Coordination of Other Benefits (COB) provisions apply to This Plan when the Member or Dependent has vision care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

If the COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

- will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
- may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first.

Benefits paid under all other Plans plus the sum of benefits paid under the Group Policy will not exceed the lesser of the financial liability of the Insured Person or the Prevailing Charge for a Treatment or Service.

Definitions

* "Plan" is any of the following that provide benefits or services for, or because of, vision care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

“Plan” includes:

* - group and nongroup insurance contracts and subscriber contracts; and
* - uninsured arrangements of group or group-type coverage; and
* - group and nongroup coverage through closed panel plans; and
* - group-type contracts; and
* - the medical care components of long-term care contracts, including skilled nursing facility care; and
  - Medicare or other governmental benefits, as permitted by law, except as provided below.

The term “Plan” will not include:

- hospital indemnity coverage benefits or other fixed indemnity coverage; or
- accident-only coverage or disability income insurance; or

- specified disease or specified accident coverage; or
- school-accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a to-and-from-school basis; or
- benefits provided in long-term care insurance policies for nonmedical services, including personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.; or
- Medicare supplement plans; or
- a state plan under Medicaid; or
- a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

Each contract for coverage above is a separate Plan. If a Plan has two parts and COB rules apply to only one of the two, each of the parts is treated as a separate Plan.

The term Plan will apply separately to those parts of any program that contain provisions for coordination of benefits with other Plans and separately to those parts of any program which do not contain such provisions.

* In the event a husband and wife are both employed by the Policyholder, each Plan will be considered a separate Plan with respect to these coordination of benefits provisions. The amount payable will not be more than 100% of the actual cost charged for Treatment or Service.

"This Plan" is the vision care expense benefits described in this booklet-certificate.

Primary Plan/Secondary Plan". The order of benefit determination rules state whether This Plan is a Primary or a Secondary Plan as to another Plan covering the person.

- When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other Plan's benefits.
- When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other plan's benefits.
- When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

"Allowable Expense" means a necessary, reasonable, and customary item of expense for vision care; when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

When benefits are reduced under a primary Plan because an Insured Person does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to preferred provider arrangements.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means the part of a calendar year during which the Member or Dependent would receive benefit payments under This Plan if this section were not in force.

Effect on Benefits

Benefits otherwise payable under This Plan for Allowable Expenses during a Claim Determination Period may be reduced if:

- benefits are payable under any other Plan for the same Allowable Expenses; and
- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under This Plan.

The reduction will be the amount needed to provide that the sum of payments under This Plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses.

For this purpose:

- benefits payable under other Plans will include the benefits that would have been paid had claim been made for them;
- for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B whether or not the person is covered under that Part B.

Order of Benefit Determination

General. Except as described below under Medicare Exception, the benefits payable of a Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

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

- **Non-Dependent/Dependent.** The Plan which covers the person as an employee, Member, or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

    - Secondary to the Plan covering the person as a Dependent; and
    - Primary to the Plan covering the person as other than a Dependent (e.g. a retired employee);

then the benefits of the Plan covering the person as a Dependent are determined before those of the Plan covering that person as other than a Dependent.

- **Dependent Child-Parents Not Separated or Divorced (or parents living together if never married).** If a Dependent Child is covered by both parents' Plans, the Plan of the parent whose birthday falls earlier in the calendar year will be determined before those of the Plan of the parent whose birthday falls later in that year. But, if both parents have the same birthday or if the other Plan does not have a birthday rule, and as a result the Plans do not agree on the order of benefits, the benefits of the Plan which covered a parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

  However, if the other Plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

  For a Dependent Child covered under more than one Plan, and one or more of the Plans provides coverage for individuals who are not the parents of the Dependent Child, such as a guardian, the order of benefits will be determined as if those individuals were parents of the Dependent Child.

  If a Dependent Child is covered under either or both parents' Plans and is also covered as a Dependent under his or her spouse's Plan, and the Dependent Child's coverage under the spouse's Plan began on the same date as coverage under either or both parents' Plans, the order of benefits is determined by applying the birthday rule described in this section to the Dependent Child's parents, as applicable, and his or her spouse.

- **Dependent Child-Separated or Divorced Parents (or parents not living together if never married).** If there is no court decree allocating responsibility for the Dependent Child's vision care expenses or vision care coverage, the order of benefits for the Dependent Child are as follows:

  - first, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child; and
  - finally, the Plan of the spouse of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the vision care expenses or coverage of the Dependent Child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. If the parent with the court decreed responsibility has no vision care coverage for the Dependent Child's vision care expenses, but the spouse of the responsible parent does have vision care coverage for the Dependent Child's vision care expenses, the responsible parent's spouse's Plan is the primary Plan. If the specific terms of a court decree state that both parents are responsible for the Dependent Child's vision care expenses or vision care coverage, the Plans covering the Dependent Child will follow the order of benefit determination rules for Dependent Children of parents who are not separated or divorced (or living together if never married). This paragraph does not apply for any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- **Joint Custody.** If the specific terms of a court decree state that the parents share joint custody, without stating that one of the parents is responsible for the vision care expenses or vision care coverage of the child, the Plans covering the Dependent Child will follow the order of benefit determination rules for Dependent Children of parents who are not separated or divorced (or living together if never married).

- **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a Plan which covers that person as a laid-off or retired employee. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **Continuation of Coverage**. If a person for whom coverage is provided under a right of continuation according to Federal or state law is also covered under another Plan, the following will be the order of benefit determination:

  - first, the benefits of a Plan covering the person as an employee, Member or subscriber (or as that person's Dependent);
  - second, the benefits under the continuation coverage.

  If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

- **Longer/Shorter Length of Coverage.** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

If a Dependent Child is covered under either or both parents' Plans and is also covered as a Dependent under his or her spouse's Plan, the order of benefits is determined in the manner described above.

If the Plans cannot agree on the order of benefits within 30 calendar days after all of the information needed to pay the claim has been received, the Company will immediately pay the claim in equal share to the other Plan and each Plan will determine their relative liabilities following payment. The Company is not required to pay more than it would have paid had its Plan been issued as the Primary Plan.

Medicare Exception

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under the Group Policy.

Federal law will usually apply in such instances if:

- the benefits are applicable to an active Member or to that Member's spouse; and
- the Member's employer has 20 or more employees.

Important Note for Members or Dependents eligible for Medicare Part B (or Part C)

Members or Dependents who are eligible for COBRA and who are age 65 or older, or who are disabled, should enroll in Medicare Part B (or Part C) because Medicare is the primary payer for vision care expenses. In this instance, the Group Policy pays secondary whether or not the Member or Dependent is actually enrolled in Medicare Part B (or Part C). Therefore, failure to enroll in Medicare Part B (or Part C) will result in significant benefit reductions.

Medicare is the primary payer under other circumstances as well. Please consider vision enrollment options carefully.

CLAIM PROCEDURES

Notice of Claim

Written notice of claim must be given to the Company within 20 calendar days after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

Claim Forms

Except in the case of vision care received from Preferred Providers, claim forms and other information needed to prove loss must be filed with the Company in order to obtain payment of benefits. The Policyholder will provide forms to assist in filing claims. If the forms are not provided within 15 calendar days after the Company receives such notice of claim, the Insured Person will be considered to have complied with the requirements of the Group Policy regarding proof of loss upon submitting, within the time specified below for filing proof of loss, Written proof covering the occurrence, character, and extent of the loss.

Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to the Company within 12 months after the date of loss. For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when the Company receives proof of loss. Proof of loss includes the patient's name, the Member's name (if different from patient's name), provider of services, dates of service, diagnosis, description of Treatment or Service provided and extent of the loss. The Company may request additional information to substantiate the Insured Person's loss or require a Signed unaltered authorization to obtain that information from the provider. The Insured Person's failure to comply with such request could result in declination of the claim.

Payment, Denial, and Review

The Employee Retirement Income Security Act (ERISA) permits up to 30 calendar days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, the Company will either deny the claim or send a Written explanation requesting information prior to the expiration of the 30 calendar days. If the Company does not deny the claim and requests additional information to complete the review, the claimant is then allowed up to 45 calendar days to provide all additional information requested. The Company will render a decision within 15 calendar days of either receiving the necessary information or upon the expiration of 45 calendar days if no additional information is received.

In actual practice, benefits will be payable sooner, provided the Company receives complete and proper proof of loss. If a claim is not payable or cannot be processed, the Company will submit a detailed explanation of the basis for its denial.

A claimant or a designated representative or provider acting on the Insured Person's behalf may request an appeal of a claim denial or file a Grievance by Written request to the Company within 180 calendar days of receipt of the notice of denial. The Written request should be sent to the local service center (the address is shown on the Insured Person's ID card). The Company will make a full and fair review of the claim. The Company may require additional information to make the review. The Company will provide timely notification to the claimant as to the progress of the review. The Insured Person has the right to appear before a designated person or committee to present oral or Written information through telephone, video, or physical conferencing, or to ask any questions pertinent to the subject of the appeal or Grievance. The Company will notify the claimant in Writing of the decision within 30 calendar days of receiving the request for post-service claims and 15 calendar days for pre-service claims. The Company will notify the claimant in Writing of the appeal decision within 72 hours for urgent care claims. The appeal review must be completed before filing a civil action or pursuing any other legal remedies.

An Insured Person or a designated representative or provider acting on behalf of the Insured Person may request an expedited review if an appeal or Grievance is submitted, either orally or in Writing, and a Physician, either orally or in Writing, substantiates that the standard time frame for an appeal or Grievance would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function. The Company will notify the claimant in Writing of the decision as expeditiously as the medical condition requires, but in no event more than 72 hours after receipt of the request for an expedited review. If the determination is made orally, the Company will provide Written confirmation of the determination to the claimant not later than 2 business days after the oral determination.

The appeal or Grievance review must be completed before filing a civil action or pursuing any other legal remedies.

After exhaustion of the formal appeal or Grievance process, a claimant may request an external review or a voluntary appeal or Grievance review. The voluntary review must be requested by fax or in Writing within 60 calendar days of receipt of the final internal Adverse Benefit Determination. The claimant may obtain the clinical rationale for an Adverse Benefit Determination by Writing the claims office. The Written request should be sent to the local service center (the address is shown on the Insured Person's ID card). The Company will make a full and fair review of the claim. The claimant may submit Written comments, documents, records, and other information relating to the claim for benefits. The Insured Person has the right to appear before a designated person or committee to present oral or Written information through telephone, video, or physical conferencing, or to ask any questions pertinent to the subject of the appeal or Grievance. The Company will make a determination within 30 calendar days of request for a voluntary review for post-service claims and 15 calendar days for pre-service claims.

Election of a second appeal or Grievance is voluntary and does not negate the claimant's right to bring civil action following the first level review, nor does it have any effect on the claimant's right to any other benefit under the Group Policy. The Company offers the voluntary review process in an effort that the claim may be resolved in good faith without legal intervention. At any time during the voluntary review process, the claimant may file a civil action or pursue any other legal remedies.

The Insured Person or a designated representative or provider acting on behalf of the Insured Person has the right to apply to the Insurance Director for an external review of an Adverse Benefit Determination or a final internal Adverse Benefit Determination.

The external review request must be in Writing and be filed within 120 calendar days of the receipt of an Adverse Benefit Determination or a final internal Adverse Benefit Determination. An expedited external review may be requested orally or in Writing within 10 calendar days after receipt of the Adverse Benefit Determination or final internal Adverse Benefit Determination if both of the following are met:

- the Adverse Benefit Determination or final internal Adverse Benefit Determination involves a medical condition of the Insured Person for which the time frame for completion of an expedited internal appeal or Grievance would seriously jeopardize the life or health of the Insured Person or would jeopardize the ability of the Insured Person to regain maximum function as substantiated by a Physician either orally or in Writing; and
- the Insured Person or a designated representative has filed a request for an expedited internal appeal or Grievance.

An Insured Person who files a request for an expedited external review is considered to have exhausted the internal appeal and Grievance process.

The Insured Person must exhaust the internal appeal and Grievance process before requesting a standard external review, unless:

- The Company has not issued a Written decision under the internal appeal and Grievance process within the required time and the Insured Person or the Insured Person's authorized representative has not requested or agreed to a delay; or
- The Company expressly waives the requirement that the Insured Person must exhaust the internal appeal and Grievance process; or
- The Company otherwise fails to comply with the internal appeal and Grievance process unless the failure or failures are based on de minimis violations that do not cause, and are not likely to cause, the Insured Person prejudice or harm.

An expedited external review is not provided for retrospective Adverse Benefit Determinations or retrospective final internal Adverse Benefit Determinations.

The Insurance Director's address and telephone number are:

Michigan Department of Insurance and Financial Services
Office of General Counsel / PRIRA
P.O. Box 30220
Lansing MI 48909-7720
www.michigan.gov/difs
1-877-999-6442

When filing a request for an external review, the Insured Person will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Upon receipt of a notice of a decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Company will immediately approve the coverage that was the subject of the Adverse Benefit Determination or final internal Adverse Benefit Determination.

As used in this section:

- "Adverse Benefit Determination" means any of the following: a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Insured Person's eligibility under the Group Policy, and including, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined not to be Medically Necessary Care, a rescission of coverage determination, or a failure to respond in a timely manner to a request for a determination.
- "Grievance" means a formal complaint concerning the availability, delivery, or quality of vision care Treatment or Service, including a complaint regarding an Adverse Benefit Determination made pursuant to utilization review; benefits or claim payment, handling, or reimbursement for vision care Treatment or Service; or matters pertaining to the contractual relationship between an Insured Person and the Company.

For purposes of this section, "claimant" means the Member or the Member's Dependent.

Preferred Providers

When a person becomes insured, such person will be issued an identification card. This card should be presented to each Preferred Provider at the time the Insured Person receives needed vision care. Each Preferred Provider will provide the Insured Person with a claim form and other filing assistance.

Facility of Payment

The Company will normally pay all benefits to the Member. However, if the claimed benefits result from a Dependent's vision care, the Company may make payment to the Dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge the Company to the full extent of those payments.

- If payment amounts remain due upon the Member's death, those amounts may, at the Company's option, be paid to the Member's estate, spouse, child, parent, or provider of vision care services.
- If the Company believes a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, the Company may, at its option, pay such benefits, up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the person who is deemed by the Company to be entitled to such payment.
- Benefits payable to a Preferred Provider will be paid directly to the Preferred Provider on behalf of the Insured Person.

Medical Examinations

The Company may have the person whose loss is the basis for claim examined by a Physician. The Company will pay for these examinations and will choose the Physician to perform them.

Legal Action

Legal action with respect to a claim may not be started earlier than 90 days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after proof is required to be filed.

Time Limits

All time limits listed in this section will be adjusted as required by law.

STATEMENT OF RIGHTS

Federal law requires that this section be included in this booklet-certificate.

As a participant in this plan the Member is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

Receive Information About the Plan and Benefits

- 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 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 the Member, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. The Member and his or her Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan or the rules governing 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 the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of the Member and other plan participants and beneficiaries. No one, including the Member’s employer, union, or any other person, may fire the Member or otherwise discriminate against the Member in any way to prevent the Member from obtaining a welfare benefit or exercising his or her rights under ERISA.

Enforcing the Member's Rights

If the Member's claim for a welfare benefit is denied or ignored, in whole or in part, the Member has 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 the Member can take to enforce the above rights. For instance, if the Member requests a copy of plan documents or the latest annual report from the plan and does not receive them within 30 days, he or she may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay the Member up to $110 a day until the Member receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the Member has a claim for benefits which is denied or ignored, in whole or in part, the Member may file suit in a state or Federal court. In addition, if the Member disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the Member may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if the Member is discriminated against for asserting his or her rights, the Member may seek assistance from the U.S. Department of Labor, or the Member may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Member is successful the court may order the person the Member has sued to pay these costs and fees. If the Member loses, the court may order the Member to pay these costs and fees, for example, if it finds the Member's claim is frivolous.

Assistance with Questions

If the Member has any questions about his or her plan, he or she should contact the plan administrator. If the Member has any questions about this statement or about his or her rights under ERISA, or if he or she needs assistance in obtaining documents from the plan administrator, the Member should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The Member may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

SUPPLEMENT
TO THE BOOKLET-CERTIFICATE

The Employee Retirement Income Security Act (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. Policyholders may use this booklet-certificate in part in meeting Summary Plan Description requirements under ERISA.

1. **Employer Plan Identification Number:**

   EIN: 38-3016622
   PN: 501

2. **Type of Administration:**

   Vision Care Expense Insurance: Insurance Contract

3. **Plan Administrator:**

   CL MOORE & ASSOCIATES SARAH J WEBER ACADEMY
   530 S PINE ST
   LANSING, MI 48933

   See the employer for the business telephone number of the Plan Administrator.

4. **Plan Sponsor:**

   CL MOORE & ASSOCIATES SARAH J WEBER ACADEMY
   530 S PINE ST
   LANSING, MI 48933

   A complete list of the employers and/or employee organizations sponsoring the plan may be obtained upon Written request to the plan administrator and is also available for examination at the business office of the plan administrator.

   Upon Written request, participants may receive from the ERISA Plan Administrator information as to whether a particular employer or employee organization is a sponsor of the ERISA Plan, and if the employer or employee organization is a plan sponsor, their address.

5. **Agent for Service of Legal Process:**

CL MOORE & ASSOCIATES SARAH J WEBER ACADEMY
530 S PINE ST
LANSING, MI 48933
Telephone: 5173717876

Legal process may also be served upon the plan administrator.

6. **Type of Participants Insured Under the Plan:**

All active Full-Time Employees of CL MOORE & ASSOCIATES SARAH J WEBER ACADEMY, and provided that, for each employee, he or she also meets the definition of a Member as defined in the DEFINITIONS section of this booklet-certificate (page NBV 136-1 (J)).

7. **Sources and Methods of Contributions to the Plan:**

Employee pays part of employee's contribution. Employee pays part of Dependent's contribution (if employee elects to enroll Dependents in plan).

8. **Ending Date of Plan's Fiscal Year:**

August 31.

DEFINITIONS

Several words and phrases used to describe insurance are capitalized whenever they are used in this booklet-certificate. These words and phrases have special meanings as explained in this section.

Allowance means the benefit available to an Insured Person for Covered Charges provided by PPO Providers.

Anti-Reflective Coating means a lens coating that allows more light to pass through the lens, cutting down on glare and distracting reflections. This coating is good for night driving and is cosmetically appealing because it allows others to see a person's eyes rather than the light reflection off the lenses.

Active Work; Actively at Work mean the active performance of all of a Member's normal job duties at the Policyholder's usual place or places of business.

Bifocal Lens means lenses prescribed to correct for both far away and up close.

Company means Nippon Life Insurance Company of America.

Complete Visual Analysis/Vision Exam includes:

- case history and professional consultation; and
- examination for disease or abnormalities; and
- determination of the ranges of clear single vision; and
- measurement of refraction, eye muscle coordination, and balance; and
- special working distance analysis.

Contact Lens Fitting (premium) means more complex applications, including but not limited to, multifocal, postsurgical, and gas-permeable of soft, spherical wear Contact Lenses for single vision prescriptions.

Contact Lens Fitting (standard) means routine applications of clear, soft, spherical, daily-wear Contact Lenses for single vision prescriptions.

Contact Lenses (conventional) means contact lenses designed for long-term use (up to one year) and can be either daily or extended wear. This benefit provides coverage for the Vision Materials only. It does not include the Contact Lens Fitting.

Contact Lenses (disposable) means contact lenses designed to be thrown away daily, weekly, bi-weekly, monthly, or quarterly. This benefit provides coverage for the Vision Materials only. It does not include the Contact Lens Fitting.

Contact Lenses (Medically Necessary) means contact lenses that are prescribed solely for the purpose of correcting one of the following medical conditions. These conditions prevent the Insured Person from achieving a specified level of visual acuity (performance) through the wearing of conventional eyeglasses.

- Aphakia (after cataract surgery). A pair of prescription Single Vision Lens or multifocal eyeglass lenses and frames can be provided in addition to Contact Lenses for this condition.
- When visual acuity cannot be corrected to 20/70 in the better eye except through the use of Contact Lenses (must be 20/60 or better).
- High Ametropia exceeding -10D or +10D in meridian powers.
- Anisometropia of 3D in meridian powers.
- Keratoconus when vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses.
- Vision improvement other than Keratoconus when vision can be corrected two lines of improvement on the visual acuity chart when compared to the best corrected standard spectacle lenses.

Reimbursement of Medically Necessary Contact Lenses will be considered as payment in-full if utilizing the services of a Preferred Provider. This benefit provides coverage for the Vision Materials only. It does not include the Contact Lens Fitting.

Copay means a specified dollar amount that must be paid by an Insured Person each time certain or specified services are rendered.

Covered Charges means the Vision Exam or Visual Service(s) or Vision Material(s) that qualify for benefits under the Group Policy. Covered Charges are shown in the Summary of Benefits.

Dependent means:

- A Member's spouse, if that spouse:

    - Resides in the United States: and
    - is not in the armed forces of any country; and
    - is not insured under the Group Policy as a Member; and
    - is legally wed to the Member.

- A Member's Dependent Child (or Children), as defined below.

Dependent Child; Dependent Children means:

- A Member's natural, stepchild or legally adopted child, if that child is less than 26 years of age.

  A newly adopted child will be considered a Dependent Child from the date of Placement with the Member for the purpose of adoption or the date of adoption, whichever is earlier. The child will continue to be a Dependent Child unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

- A Member's foster child, provided:

  - the child meets the requirements above; and
  - the child has been placed with the Member or the Member's spouse insured under this booklet-certificate by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction; and
  - the required documentation has been provided and the child is approved in Writing by the Company as a Dependent Child.

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to the Group Policy, provided the child meets the Group Policy's definition of a Dependent Child.

Developmental Disability means a Dependent Child's substantial handicap, as determined by the Company, which:

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and
- is diagnosed by a Physician as a permanent or long-term continuing condition.

Dilation means the process of administering special pharmaceutical eye drops into the eyes in order to enlarge the pupils. Dilating the pupil allows in more light and facilitates the view of the internal structures of the eye including the lens, optic nerve, blood vessels, and retina in greater detail. Dilation is a key component of an exam as it sometimes leads to the detection and diagnosis of certain eye diseases, possibly at their earliest stages, which include diabetes, high blood pressure, macular degeneration, retinal detachment, and glaucoma.

Eligibility Waiting Period means with respect to a group vision plan and an individual who is a potential enrollee in the plan, the period of time that must pass before insurance for an individual who is otherwise eligible to enroll for benefits under the terms of the plan can become effective.

Full-Time Employee means any person who is regularly scheduled to work for the Policyholder for at least 30 hours a week. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties.

An owner, proprietor, or partner of the Policyholder's business will be deemed to be an eligible employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least 30 hours a week and otherwise meets the definition of Full-Time Employee.

Full-Time Student means a Member's Dependent Child attending a school that has a regular teaching staff, curriculum and student body and who:

- attends school on a full-time basis, as determined by the school's criteria; and
- is dependent on the Member for principal support.

Generally Accepted means Treatment or Service which:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed vision and scientific literature; and
- is in general use in the relevant vision community; and
- is not under continued scientific testing or research.

Group Policy means the policy and booklet-certificate of group insurance issued to the Policyholder by the Company which describes benefits and provisions for the Policyholder and Insured Persons.

Immediate Family means an Insured Person's spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

Insurance Month means calendar month.

Insured/Insured Person means a Member or Dependent who:

- applied for insurance; and
- meets the eligibility rules set forth in the Group Policy; and
- is approved for insurance by the Company; and
- for whom all applicable premiums are paid, and is therefore insured.

When Insured is used alone, it does not include the Dependent.

When Dependent is used alone, it does not include the Member.

LASIK or PRK means a type of refractive eye surgery for correcting myopia (nearsightedness), hyperopia (farsightedness), and astigmatism. LASIK is performed by an Ophthalmologist using a laser to remove the inner layers of corneal tissue. PRK (photorefractive keratectomy) is a kind of laser eye surgery used to remove the outer layer of the cornea and flatten the cornea.

Late Enrollee means a Member or Dependent who enrolls more than 31 days after the date the Member or Dependent is eligible other than during a Special Enrollment Period. The term also means a Member or Dependent who:

- was previously insured under the Group Policy but elected to terminate the insurance; and
- reapplies for insurance more than 31 days after the termination date; and
- does not qualify for one of the Special Enrollment Periods.

Lens Options or Add-Ons means any lens option or add-on that does not come with the basic lens.

Lenticular Lens means an antiquated technology used in situations requiring such high plus power that a full field meniscus lens would be impractical (because of thickness, weight, and fit). This area of power is usually located in the center of the lens and takes on the appearance of a "bubble".

Medically Necessary means as determined by the Company, any Visual Services or Vision Materials that are prescribed by an Ophthalmologist, Optometrist or Optician and considered to be necessary and appropriate and not in conflict with Generally Accepted medical standards.

Member means any person (other than PART-TIME, SUBSTITUTE TEACHERS) who Resides in the United States and is a Full-Time Employee of the Policyholder.

Non-Preferred Provider(s)/Non-PPO Provider(s) means an Ophthalmologist, Optometrist, or Optician not contracted with the Preferred Provider Organization (PPO) network identified by the Company to the Group Policy.

Ophthalmologist means a person who is licensed by the state in which he or she practices as a Doctor of Medicine (M.D.) or Osteopathy (D.O.) and is qualified to practice within the medical specialty of ophthalmology. The Ophthalmologist cannot be 1) the Insured Person; 2) an Immediate Family member; or 3) retained by the Policyholder.

Optician means a person or business that grinds and/or dispenses eyeglass lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician cannot be: 1) the Insured Person; 2) an Immediate Family member; or 3) retained by the Policyholder. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.

Optometrist means a person licensed to practice optometry as defined by the laws of the state in which services are rendered. The Optometrist cannot be 1) the Insured Person; 2) an Immediate Family member; or 3) retained by the Policyholder.

Photochromic/Transitions Lens means lenses that change color based on different levels of light.

Physical Handicap means a Dependent Child's substantial physical or mental impairment, as determined by the Company, which:

- results from injury, accident, congenital defect or sickness; and
- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

Physician means:

- a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.); or
- any other licensed health care practitioner that state law requires to be recognized as a Physician under the Group Policy.

Whether or not required by state law, the following licensed or certified health care practitioners will be recognized, on the same basis as a Physician, for Covered Charges of services performed within the scope of their license: optometrist and physician's assistant.

Placement for Adoption; Placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Plano Lens means a lens that has no refractive power.

Polarized means a lens add-on that cuts down on glare from the sun.

Policy Anniversary means September 1, and the same day of each following year.

Policyholder means the business, firm, trustee(s), or other entity to whom the Group Policy is issued (see Title Page).

Preferred Provider(s)/PPO Provider(s) means an Ophthalmologist, Optometrist, or Optician contracted with a Preferred Provider Organization (PPO) network identified by the Company to the Group Policy.

The Policyholder's participation in a PPO network does not mean that an Insured Person's choice of provider will be restricted. The Insured Person may seek needed vision care from any Ophthalmologist, Optometrist or Optician of his or her choice. However, in order to avoid higher charges and reduced benefit payment, the Insured Persons are urged to obtain such care from Preferred Providers whenever possible.

Preferred Provider Organization (PPO) Service Area means the geographic area within which Preferred Provider services are available to persons insured under the Group Policy.

Premium Progressive Lens means multifocal lenses that produce a gradual change in focus without lines or junctions and are the latest technology. These designs are the lens manufacturer's highest technology models and produce the optimal ease of adaptation, comfort, and widest zones for reading and intermediate vision. The determination of a Premium Progressive Lens designation takes into consideration the date the design was introduced to the market, the technology/design features, advantages and benefits and the wholesale list price from the manufacturer's laboratory.

Reside(s) in the United States means a Member and Dependent who:

- maintain a home in the United States; and
- live in that home in the United States; and
- do not leave the United States for more than six consecutive months.

Retinal Imaging means a diagnostic tool that provides high-resolution, permanent digital records of the inner eye.

Rolling Benefit Plan means benefits begin anew from the date of service as described in the SUMMARY OF BENEFITS section on page NBV 102-1 (J) (PPO).

Signed or Signature means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by the Company.

Single Vision Lens means lenses prescribed to correct for one field of vision: either far away or up-close.

Standard Plastic Scratch Coating means a film or coating that can be applied to optical surfaces. The coating does not interfere with how the lens functions and does not affect vision, but creates a permanent bond with the lens that reduces the appearance of hairline scratches which is common to standard plastic lenses. Though an anti-scratch coating is not 100% scratch-proof, it helps to prevent minor scratches that can easily happen to a regular lens. These minor scratches can damage the surface of the lens and impair vision. An anti-scratch coating acts as a protective layer making the lenses more durable and safe.

Standard Polycarbonate means lenses that are more durable than regular plastic lenses, and are very lightweight. They also have greater impact resistance than any other lens material, making them the lenses of choice for sports eyewear, children, or those with active lifestyles.

Standard Progressive Lens means multifocal lenses that produce a gradual change in focus without lines or junctions but may not be each manufacturer's most current models. The determination of a Standard Progressive Lens designation takes into consideration the date the design was introduced to the market, the technology/design features, advantages and benefits and the wholesale list price from the manufacturer's laboratory.

Treatment or Service, when used in this booklet-certificate, will be considered to mean: "treatment, service, substance, material or device".

Tint (Solid and Gradient) means a lens add-on that reduces the light that enters the eyes. This can be physician recommended or for fashion purposes.

Trifocal Lens means lenses prescribed to correct for three fields of vision: far away, up-close, and intermediate.

United States (U.S.) means the contiguous United States consisting of the 48 adjoining U.S. states plus Washington, D.C. (federal district), Alaska, and Hawaii, on the continent of North America.

UV Coating means an eyeglass lens coating that protects eyes from harmful ultraviolet light found in sunlight.

Vision Material(s) means corrective eyeglass lenses, frames, and Contact Lenses.

Visual Service(s) means any services or treatment by an Ophthalmologist, Optometrist or Optician, including but not limited to a Complete Visual Analysis/Vision Exam.

We, Us, and Our mean Nippon Life Insurance Company of America, West Des Moines, Iowa.

Written or Writing means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

Nippon Life Benefits®

Notice of Privacy Practices for Protected Health Information (HIPAA)

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.

This Notice describes how your medical information obtained in connection with your health benefit plan administration may be used and disclosed and how you can access the information. The terms of this Notice apply to current and former plan members and dependents for their group medical expense, group dental expense and/or group vision care expense insurance. This Notice was effective April 14, 2003 and has been revised most recently effective November 1, 2013.

We are required by law to maintain the privacy of our current and former members' and dependents' protected health information, to provide notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all protected health information maintained by us. Copies of any revised Notices will be mailed to plan sponsors for distribution to the members then covered by the plan. You have the right to request a paper copy of the Notice, although you may have originally requested a copy of the Notice electronically by e-mail.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Authorization

Except as explained below, we will not use or disclose your protected health information for any purpose unless you have signed an authorization form. You have the right to revoke an authorization by written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to revoke an authorization can be obtained from the Privacy Officer and will be honored upon receipt by us.

Disclosures for Treatment

We may disclose your protected health information as necessary for your treatment. For instance, a doctor or healthcare facility involved in your care may request your protected health information in our possession to assist in your care.

Uses and Disclosures for Payment

We may use and disclose your protected health information as necessary for payment purposes. For instance, we may use it to process or pay claims, to exercise legal subrogation rights, to perform a Precertification, to determine whether services are for medically necessary care, or to perform prospective reviews. We may also forward information to another insurer in order for them to process or pay claims on your behalf.

Uses and Disclosures for HealthCare Operations

We may use and disclose your protected health information as necessary for health care operations. For instance, we may use or disclose your protected health information for quality assessment and quality improvement, premium rating (when allowable by law), conducting or arranging for medical review or compliance. We may also disclose your protected health information to another insurer, health care facility or health care provider for activities such as quality assurance or case management. We participate in an organized health care arrangement with your health plan. Your health plan may have its own privacy practices that are not reflected in this Notice. We may disclose your protected health information to your health plan for its health care operations. We may contact your health care providers concerning prescription drug or treatment alternatives.

Other Health-Related Uses and Disclosures

We may contact you to provide reminders for appointments; information about treatment alternatives; or other health-related programs, products or services that may be available to you.

Information Received Pre-enrollment

We may request and receive from you and your health care providers protected health information prior to your enrollment under the group policy. When allowable by law, we may use this information to determine rates. If you do not enroll, we will not use or disclose the information we obtained about you for any other purpose. Information provided on enrollment forms or applications will be utilized for all coverages being applied for, some of which may be protected by the state privacy laws.

Genetic Information

We will not use or disclose any genetic information we obtain about you in any regard, including underwriting purposes.

Business Associate

Certain aspects and components of our insurance services are performed by outside vendors known as 'Business Associates.' Business Associates are under an independent duty to safeguard your privacy. Additionally we require them to sign a Business Associate Agreement, which is a contract to adhere to our privacy practices.

Plan Sponsor

We may disclose your protected health information to the plan sponsor, provided that the plan sponsor certifies that the information will be used and maintained in a compliant confidential manner and will not be utilized or disclosed for employment-related actions or decisions or in connection with any other benefit plan of the plan sponsor.

Family, Friends and Personal Representatives

With your approval, we may disclose to family members, close personal friends, or another person you identify, your protected health information relevant to their involvement with your health care or paying for your care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your protected health information without your approval. We may also disclose your protected health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures

We are permitted or required by law to use or disclose your protected health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with workers' compensation programs.

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV-related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulation.

Uses and Disclosures Requiring Authorization

We are required by law to obtain your authorization prior to using or disclosing your protected health information in the following circumstances:

- Uses and disclosures of protected health information for marketing purposes.
- Uses and disclosures that constitute the sale of protected health information.
- Most uses and disclosures of psychotherapy notes.
- Other uses and disclosures not described in this notice will be made only with the individual's written authorization. An individual may revoke an authorization, provided that the revocation is in writing and we have not taken action in reliance upon the authorization.

YOUR RIGHTS

Restrictions on Use and Disclosure of Your Protected Health Information

You have the right to request restrictions on how we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. To request a restriction, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951.

A form to request a restriction can be obtained from the Privacy Officer. We are not required to agree to your request for a restriction. If your request for a restriction is granted, you will receive a written acknowledgement from us.

Receiving Confidential Communications of Your Protected Health Information

You have the right to request communications regarding your protected health information from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests. To request a confidential communication, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request a confidential communication can be obtained from the Privacy Officer.

Access to Your Protected Health Information

You have the right to inspect and/or obtain a copy of your protected health information we maintain in your designated record set, with some exceptions. To request access to your information, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request access to your protected health information can be obtained from the Privacy Officer. A fee may be charged for copying and postage.

Amendment of Your Protected Health Information

You have the right to request an amendment to your protected health information to correct inaccuracies. To request an amendment, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request an amendment to your protected health information can be obtained from the Privacy Officer. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your Protected Health Information

You have the right to receive an accounting of certain disclosures made by us after April 14, 2003, of your protected health information. To request an accounting, you must send a written request to: Privacy Officer, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951. A form to request an accounting of your protected health information can be obtained from the Privacy Officer. The first accounting in any 12-month period will be free; however, a fee may be charged for any subsequent request for an accounting during that same time period.

Complaints

If you believe your privacy rights have been violated, you can send a written complaint to us at Grievance Coordinator, Nippon Life Insurance Company of America, P.O. Box 25951, Shawnee Mission, Kansas 66225-5951 or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

IF you have any questions or need any assistance regarding this Notice or your privacy rights, you may call Nippon Life Insurance Company of America at: English and Non-English (800) 374-1835; Japanese (800) 971-0638; or Korean (877) 827-8713.

Nippon Life Insurance Company of America
P.O. Box 25951
Shawnee Mission, Kansas 66225-5951