

**STANDARD INSURANCE COMPANY**

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

**CERTIFICATE AND SUMMARY PLAN DESCRIPTION  
GROUP EYE CARE INSURANCE**

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**The Policyholder**      **NEBRASKA BANKERS ASSOCIATION VOLUNTARY EMPLOYEE  
BENEFICIARY ASSOCIATION  
NBA VEBA**

**Policy Number**      **160-645708**      **Insured Person**

**Plan Effective Date**      **January 1, 2010**      **Certificate Effective Date**  
**Refer to Exceptions on 9070.**

**Plan Change Effective Date**      **March 25, 2014**

**Class Number 2**

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

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

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

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

**STANDARD INSURANCE COMPANY**



J. Greg Ness  
President



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**SCHEDULE OF BENEFITS  
OUTLINE OF COVERAGE**

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

Benefit Class

Class Description

Class 2

Eligible Employee Electing The Balanced Care Vision Plan Iii

**EYE CARE EXPENSE BENEFITS**

Deductible Amount:

Exam, Lenses, and Frames - Each Benefit Period

\$20

Contact Lenses

\$0

*Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.*



## DEFINITIONS

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

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

**INSURED** refers to a person:

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

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

**DEPENDENT** refers to:

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

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

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

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

**TOTAL DISABILITY** describes the Insured's Dependent as:

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

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

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

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

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

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



## **CONDITIONS FOR INSURANCE COVERAGE**

### *ELIGIBILITY*

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

If employment is the basis for membership, to be eligible for this coverage, you must work a minimum of 17.5 hours per week, or the number of hours weekly required by your employer bank, whichever is higher. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

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

If employment is the basis for membership, to be eligible for dependent coverage, you must work a minimum of 17.5 hours per week, or the number of hours weekly required by your employer bank, whichever is higher. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

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

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

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

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

**ELIGIBILITY PERIOD.** For Members on the Plan Effective Date of the policy, coverage is effective immediately.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur after an eligibility period defined by the Policyholder is satisfied. The same eligibility period will be applied to all members.

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

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

**EXCEPTIONS.** A Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

### ***TERMINATION DATES***

**INSUREDS.** The insurance for any Insured, will automatically terminate on the **earliest of:**

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

**DEPENDENTS.** The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

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

The insurance for any Dependent will automatically terminate on the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

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

## EYE CARE INSURANCE

If an Insured under this section incurs Covered Expenses, we will pay benefits as stated below.

**AMOUNT PAYABLE.** The Amount Payable for Covered Expenses shall be the lesser of:

- a. the charge for frames or supplies furnished; or
- b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Procedures.

**COVERED EXPENSES.** Covered Expenses means the Eye Care expenses incurred by an Insured for the procedures shown in the Schedule of Procedures, up to the Maximum Covered Expense shown for each procedure and the Eye Care Maximum as shown in the Schedule of Benefits, if applicable. But such expenses will be Covered Expenses only to the extent that they are incurred for procedures done by a physician, optometrist, or optician. These expenses are subject to the "Limitations" below.

Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

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

**EXTENSION OF BENEFITS.** Should an Insured's coverage under this section terminate, we will pay Covered Expenses for frames or lenses which were ordered while coverage was in force, provided such frames or lenses are delivered within 30 days from the date the Insured's coverage ceases.

**LIMITATIONS:** Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. vision examinations more than once in any 12 month period.
2. prescribed lenses more than once in any 12 month period.
3. frames more than once in any 24 month period.
4. contact lenses more than once in any 12 month period. When chosen, contact lenses shall be in lieu of any other lens or frame benefit during the 12 month period. When lenses are chosen, expenses for contact lenses are not Covered Expenses during the 12 month period.
5. examinations performed or frames or lenses ordered before the Insured was covered under this section.
6. subject to Extension of Benefits, any examination performed or frame or lens ordered after the Insured's coverage under this section ceases.
7. sub-normal vision aids; orthoptic or vision training or any associated testing.
8. non-prescription lenses.
9. replacement or repair of lost or broken lenses or frames except at normal intervals.
10. any eye examination or corrective eyewear required by an employer as a condition of employment.
11. medical or surgical treatment of the eyes.

12. any service or supply not shown on the Schedule of Eye Care Services.
13. coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.

### **SCHEDULE OF EYE CARE SERVICES**

The following is a complete list of eye care services for which benefits are payable. No benefits are payable for a service which is not listed.

<b>SERVICE</b>	<b>MAXIMUM COVERED EXPENSE</b>
<b>Vision Examination</b>	Up to \$ 50.00
<p>May consist of, but not limited to, the following: case history; external examination of the eye and adnexa; ophthalmoscopic examination; determination of refractive status; binocular balance testing; tonometry test for glaucoma, when indicated; gross visual fields, when indicated; color vision testing when indicated; summary finding; prescribing of lenses.</p>	
<b>Materials</b>	
Frame	Up to \$ 80.00
Lenses	
Single Vision	Up to \$ 40.00
Bifocal	Up to \$ 60.00
Trifocal	Up to \$ 75.00
No line bifocal or progressive power	Up to \$ 80.00
Lenticular	Up to \$ 80.00
Contact Lenses	Up to \$100.00

## GENERAL PROVISIONS

**NOTICE OF CLAIM.** Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

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

**PROOF OF LOSS.** Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

**TIME OF PAYMENT.** We will pay all benefits immediately when we receive due proof. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

**PAYMENT OF BENEFITS.** Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

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

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

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

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

**INCONTESTABILITY.** No statements, except fraudulent statements, made by the applicant in the application for such policy shall be used to void the policy or deny a claim as defined in the policy, commencing after the expiration of the 1 year period.

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



## ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

### A. General Plan Information

Name of Plan: Eye Care Insurance

Name, Address of Plan Sponsor: NEBRASKA BANKERS ASSOCIATION VOLUNTARY  
EMPLOYEE BENEFICIARY ASSOCIATION  
  
233 S 13TH ST STE 700  
LINCOLN, NE 68508

Plan Sponsor Tax ID Number: 47-0639387

Plan Number: 501

Type of Plan: Group Insurance Plan

Name, Address, Phone  
Number of Plan Administrator: KAREN COUFAL  
NEBRASKA BANKERS ASSOCIATION VOLUNTARY  
EMPLOYEE BENEFICIARY ASSOCIATION  
233 S 13TH ST STE 700  
LINCOLN, NE 68508  
888-419-8322

Name, Address of Registered Agent  
for Service of Legal Process: Plan Sponsor

If Legal Process Involves Claims  
For Benefits Under The Group  
Policy, Additional Notification of  
Legal Process Must Be Sent To: Standard Insurance Company  
1100 SW 6<sup>th</sup> Ave  
Portland OR 97204-1093

Sources of Contributions: Employer/Member

Funding Method: Standard Insurance Company--Fully Insured

Plan Fiscal Year End: December 31

Type of Administration:  
General Administration Plan Sponsor  
Contract & Claim Administration Standard Insurance Company

### B. Notice of Legal Process

Service of legal process may be made upon the plan administrator at the address listed above.

### **C. Eligibility and Benefits Provided Under the Group Policy**

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

### **D. Qualified Medical Child Support Order ("QMCSO")**

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

### **E. Termination Of The Group Policy**

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

After the first policy year, Standard Insurance Company may also terminate the Group Policy on any Premium Due Date for any reason by providing a 60-day advance written notice to the Policyholder.

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

### **F. Claims For Benefits**

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

### **G. Continuation of Coverage Provisions (COBRA)**

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

#### **i. Definitions For This Section**

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

A Qualifying Event occurs when:

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



referred to as Qualifying Event 4);

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

**ii. Electing COBRA Continuation**

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

**iii. Notice Requirements**

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

the Plan Administrator of the disability in writing within 60 days of the later of:

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

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

**iv. COBRA Continuation Period**

1. 18-month COBRA Continuation

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

2. 29-month COBRA Continuation

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

3. 36-Month COBRA Continuation

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

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

36 months.

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

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

v. **Premium Requirements**

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

18 month continuation - 102%

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

36 month continuation - 102%

vi. **When COBRA Continuation Ends**

COBRA continuation ends on the earliest of:

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

**H. Your Rights under ERISA**

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

**Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by

the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

### **Continue Group Health Plan Coverage**

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

### **Prudent Actions by Plan Fiduciaries**

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

### **Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance with Your Rights**

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration.

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

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

**CLAIMS FOR BENEFITS**

Claims may be submitted by mailing the completed claim form along with any requested information to:  
Standard Insurance Company  
PO Box 82622  
Lincoln, NE 68501-2622

**NOTICE OF DECISION OF CLAIM**

We will evaluate your claim promptly after we receive it.

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

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

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

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

**APPEAL PROCEDURE**

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

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

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

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

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

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

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

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

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

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

Any request for appeal should be directed to:

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

## *HIPAA Notice of Privacy Practices*

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

**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.**

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

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

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

### *Permitted Uses and Disclosures of Your Health Information*

We will disclose health information about you when required to do so by federal, state or local law. For example, we may disclose health information when required by a court order, subpoena, warrant, summons or similar process. The following describes the purposes for which The Standard is permitted or required by law to use or disclose your Health Plan coverage information without your authorization:

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

**Payment.** This means activities to facilitate payment for the treatment and services you receive from health care professionals, including to obtain premium, to determine eligibility, coverage or benefit responsibilities under your insurance coverage, or to coordinate your insurance coverage. For example, the information on claim forms sent to us may include information that identifies you, as well as your diagnosis, and the procedures and supplies used. We may share this information with outside health care consultants performing a business service for The Standard. Likewise, we may share health information with other insurance carriers to coordinate benefit payments.

We mail Explanation of Benefits forms and other information to the address we have on record for the primary member. In addition, claim information may be accessible through our website requiring an access code and our toll-free number.

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

contract agree to abide by the same high standards of safeguarding your health information. We are prohibited from using or disclosing your genetic health information for underwriting purposes.

**Public Health Activities.** We may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury (including abuse) or disability, or to a governmental agency or regulator with health care oversight responsibilities.

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

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

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

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

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

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

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

**Disclosure to your Plan Sponsor.** Information may be disclosed to your plan sponsor for purposes of plan administration if the plan sponsor has certified that plan documents have been amended as required by HIPAA. De-identified summary health information may be disclosed to your plan sponsor for the purposes of obtaining health insurance bids or modifying, amending, or terminating the health plan.

**Psychotherapy Notes.** Most uses and disclosures of your psychotherapy notes require your authorization.

**Sale of Protected Health Information.** We must obtain your authorization prior to selling your health information. If we will obtain financial remuneration for such sale, we must disclose that to you in the authorization.

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



**Marketing.** We must obtain your authorization prior to using or disclosing your health information for marketing purposes in most situations. If we will obtain financial remuneration for such marketing, we must disclose that to you in the authorization.

### ***Your Rights Regarding Your Health Information***

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

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

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

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

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

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

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

**Right to Request Restrictions.** You have the right to request a restriction or limitation of the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to your request unless your request is to restrict disclosure to a health plan for purposes of payment or health care operations when you or someone on your behalf (but not the health plan) has already made full payment.

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

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

**Right to Breach Notification.** We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your health information. We are also required by law to notify affected individuals following a breach of unsecured health information.

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

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

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

***Privacy Contact***

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

This notice is revised effective September 9, 2013.

